Ft. Ord and Silas B. Hays Hospital Closure Lessons Learned

Study Report

March 1, 1995

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at the Naval Postgraduate School

Study conducted by the
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in collaboration with the Study Center

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13. ABSTRACT In September 1993, the Secretary of Defense designated the closure and redevelopment of Ft. Ord as a national model. In July 1994, he asked that a report be developed on the lessons learned from the closure of the large base hospital and the significant shifts in health care delivery in the region. This is the resulting report. It provides insights and recommendations from four years of experience dealing with the dramatic changes associated with the closing of a military base and a significant military hospital (Silas B. Hayes Army Community Hospital). This report outlines the activities leading to the implementation of the closure, summarizes the community and organizational responses, describes the information and educational components of the closure process, relates the activities involved in transition and closure, and describes planning and development now underway to address health care needs of current beneficiaries. Specific lessons learned are provided in each Chapter with suggested recommendations. A community reaction model is illustrated, with policy, organizational and educational recommendations which can assist other communities who face similar challenges of base and health care facility closures.

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Monterey Regional Health Development Group, Inc.

P.O. Box 8748
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March 1, 1995

From: Chairman of the Board
To: Secretary of Defense
Via: Assistant Secretary of Defense (Force Management Policy)
Undersecretary of Defense

Subj: **Ft. Ord and Silas B. Hays Hospital Closure Lessons Learned**

Ref: (a) Ft. Ord Reuse Authority (FORA) Meeting of July 8, 1994

Encl: (1) *Ft. Ord and Silas B. Hays Hospital Closure--Lessons Learned* Study Report of March 1, 1995

In September 1993, and again in July 1994, we were privileged to have you visit Ft. Ord, California and meet with leaders of the civilian community. During reference (a) we discussed progress on the reuse and redevelopment of Ft. Ord, provided short briefings on the downsizing and closure of the military hospital on the base, and discussed the efforts underway to ensure the best possible transition of health care delivery to the 29,500 eligible beneficiaries remaining in the area.

Following your two visits, you expressed interest in developing lessons learned from the closure of the Ft. Ord Hospital because those lessons could be of benefit to the DoD at future base closure sites, and to the civilian communities faced with similar challenges.

The Monterey Regional Health Development Group, Inc. (MoReHEALTH), with assistance from the Health Resources Study Center (HRSC) located at the Naval Postgraduate School in Monterey, has now completed a study on the hospital closure and has prepared the enclosed report of lessons learned. The report outlines the complexities and dynamics of a hospital closure and the impacts on the beneficiary population as well as on the civilian health care delivery system. The report ends with an update on the current status of military health care delivery in the region and provides some observations on DoD health care programs for the future.

We trust that the enclosed report will prove beneficial to those who receive and study its contents. We stand ready to respond to your questions, and if you desire, to work with your staff to bring this information to bear at current and future BRAC sites.

Very Respectfully,

William H. Gourley
MG, USA (Retired)

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Mr. Leon Panetta, Chief of Staff, The White House

EXECUTIVE SUMMARY

FT. ORD AND SILAS B. HAYS HOSPITAL CLOSURE--LESSONS LEARNED

The introduction section to this report below outlines the overall Base Closure process which has taken place since 1991. It briefly summarizes the work of three successive community organizations involved in the development of a reuse strategy and the subsequent Base Reuse Plan. Major changes to the military health care delivery system are discussed to include: the departure of 14,000 active duty personnel and their 17,000 family members from the area; the phased downsizing and closure of the hospital; and, the shift to other health care delivery systems for the 5,000 active duty personnel and 24,500 total eligible DoD beneficiaries who remained in the Ft. Ord region after the closure of the base and its hospital.

Chapter 1 (Organizational Response) discusses how the military and the civilian community organized to respond to the closure of the Silas B. Hays Army Community Hospital (SBHACH) at Ft. Ord. It tracks the efforts of the hospital commander and his staff from July 1991 to July 1994 when the doors of the hospital closed. It also discusses the three successive community organizations which were involved in planning for and responding to the changes. From an organizational perspective, some of the major lessons learned are that:

- The military and civilian health care systems must be proactive in coordinating their efforts, and design an organization which can respond to the effects of a military hospital closure.
- The organization so designed must also be responsive to or a part of the civilian group which is responsible for the Base Reuse Plan because it must include planning for the reuse of medical facilities and equipment as well as the care for the replacement population.

Chapter 2 (Information and Education) discusses the information and data required to develop good plans by both the military and civilian health care systems. Then, the discussion focuses on the requirement to educate the military hospital staff, the DoD beneficiary population, the civilian health care providers, and the Base Reuse planning organization. With regard to information and education, major lessons learned are that:

- Good baseline information is essential to good planning. Standard military data sources may not be totally accurate and must be augmented by a carefully designed survey from which to begin planning, measure progress, and determine results.
- Educational programs are essential to successfully complete the major transition associated with the closure of a military hospital. Several pro-active approaches must be designed to reach the DoD eligible population. This requires funding.
- Educational programs must be designed to reach and expand the civilian health care provider network.

Chapter 3 (Transition and Closure) outlines the major events during the phased downsizing and closure of the Ft. Ord Hospital. All these changes took place during the 12-month period between July 1993 and July 1994. First, outlying clinics (PRIMUS) were closed. The CHAMPUS PRIME and EXTRA program network was expanded. Specialty care at the hospital was reduced. The Emergency Room was reduced to an Acute Care Clinic. The DoD contractor for managed care was changed and the program renamed TRICARE. Hospital inpatient care was terminated. Finally, the hospital closed on June 30, 1994, and the area military medical care responsibilities transferred to the California Medical Detachment, Monterey Bay Region. Some of the major lessons learned from the transition and closure are that:

- The process to disengage beneficiaries from care at the hospital and assign them to other DoD managed care or MEDICARE programs takes constant and professional effort by the hospital staff.
- Those beneficiaries aged 65 and over require special attention because they are transferred to MEDICARE, may require a waiver for Part B coverage, may not have planned for supplemental insurance or the increased cost of MEDICARE, and feel abandoned by the DoD system.
- The change in the DoD contractor for managed care in February 1994 was difficult. Beneficiaries were confused. A new network of physicians and hospitals had to be established. If at all possible, changing contractors at mid-stream of a hospital closure must be avoided.
- Pharmaceuticals are extremely important to the beneficiary population and especially to those 65 and over who are switched to MEDICARE. Special legislation for base closure areas and the new DoD mail-in system have been most effective.

Chapter 4 (Current Status) provides an update on the delivery of health care to DoD eligible beneficiaries in the Monterey and Ft. Ord region. The results of the Military Health Services System (MHSS) surveys conducted prior to and after the closure of the Ft. Ord hospital are compared. Next, the steps taken to establish a Department of Veterans Affairs clinic on Ft. Ord are outlined. Finally, there is a discussion regarding the emerging DoD health care system which will be instituted nationwide between 1995 and 1997. Major lessons learned are that:

- Well designed surveys with proper timing are extremely important in determining the status of health care delivery both before and after a base hospital closure.
- A survey system now exists which can develop the data and information required.
- The VA can play an important role in health care delivery in a base closure area. This is especially true with the very recent decision that the VA can be a participant in the DoD CHAMPUS TRICARE provider network.
- As the DoD applies the new CHAMPUS TRICARE program nationwide, care must be taken to provide flexibility in allowable rates paid in diverse geographic areas.
- Every effort must be made to create a "seamless" system of managed health care for DoD beneficiaries to include those age 65 and over.

Chapter 5 (Observations For The Future) looks ahead at the continuation of health and human services to area beneficiaries. It begins by comparing the Ft. Ord closure experience to a theoretical model explaining how communities react to the announcement and implementation of a base closure. Several ongoing initiatives are described including the creation of a continuing care retirement community, a VA medical center outpatient satellite clinic, and the California State University at Monterey Bay. Information about future conferences is provided with some final suggestions regarding how to apply the lessons learned from the Ft. Ord experience to other communities.

LIST OF LESSONS LEARNED

FT. ORD AND SILAS B. HAYS ARMY HOSPITAL CLOSURE--LESSONS LEARNED

ACKNOWLEDGEMENTS

FT. ORD AND SILAS B. HAYS ARMY HOSPITAL CLOSURE--LESSONS LEARNED

This study was conducted by the Monterey Regional Health Development Group, Inc. located in Monterey, California. The content reflects the views of the authors, and does not necessarily represent the views of the Department of Defense. The report is the result of three years of collaborative, volunteer effort by the individuals, and organizations listed below.

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INTRODUCTION

FT. ORD AND SILAS B. HAYS ARMY HOSPITAL CLOSURE--LESSONS LEARNED

This report describes many of the lessons learned from the perspective of community and military leaders upon closure of Silas B. Hays Army Community Hospital (SBHACH) at Ft. Ord, California. The decision to close the hospital was the result of actions in 1991 by the Department of Defense (DoD) and the Base Realignment and Closure (BRAC) Commission. This resulted in a unique situation where over 5,000 active duty personnel remained in the area after the closing of the military hospital. This report is a collaborative effort by the Monterey Regional Health Development Group, Inc. (MoReHEALTH) and the Defense Health Resources Study Center (DHRSC)[1] in response to the Secretary of Defense's request to create a compendium of lessons learned. It is anticipated that the report will assist the DoD in its future health care planning and also assist those military and civilian communities faced with the closure of a military installation and the loss of their military hospital.

SUMMARY OF THE BASE CLOSURE PROCESS AT FT. ORD

Ft. Ord has been a major Army installation on the central coast of California since 1917. It served initially as a training center and then as the home of the 7th Infantry Division (Light). The installation occupied 28,000 acres of beach front and rolling hills on Monterey Bay. The developed area of Ft. Ord includes barracks, motor pools, housing areas, sports and other support facilities, a military hospital, a troop medical clinic and three dental clinics. Approximately 14,000 soldiers and their 17,000 family members were assigned to Ft. Ord.[2] Maps of the region and a Ft. Ord locator map are included at Appendix A.

Following the BRAC decisions of July 1991, the Army was directed to:

- Move the 7th Division and its support units to Ft. Lewis, Washington.
- Downsize the base to an enclave consisting of housing units and support facilities to accommodate the needs of the 5,000 military personnel remaining at the Defense Language Institute (DLI) at the Presidio of Monterey (POM) and the Naval Postgraduate School (NPS) located in Monterey.
- Close the hospital.
- Dispose of all property except that within the enclave necessary to support the DLI and NPS.

The base realignment and closure process (BRAC) is complex, involves a large number of governmental agencies, and requires close coordination between the military and the civilian community. Some of the major steps in the process include:

- Developing the military plan for the downsizing or closure of the installation. This plan is contingent upon troop movements, the budget, transportation and other considerations. The plan changes with time.

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[1] The Health Resources Study Center (HRSC), formerly called the Defense Health Resources Study Center (DHRSC), is a functional arm of the Naval Postgraduate School in Monterey, California.

[2] *Ft. Ord Task Force Strategy Report*, June 1992, pg 3 (copy on file with Ft. Ord Reuse Authority).

- Formation of a community organization to begin development of a reuse/redevelopment plan to include alternative land use scenarios.

- The Army's preparation of an Environmental Impact Statement (EIS).

- The study of environmental cleanup requirements and actual cleanup.

- The federal screening process for the disposition of property according to established priorities (e.g., other federal agencies, McKinney Act for the homeless agencies, state and local governments, and other public and private enterprises).

- Requests for and decisions on public benefit conveyances for property to be used for: health/medical, parks/recreation, education, aviation or other purposes.

- Addressing health and health care issues which form a key part of any socio-economic redevelopment plan.

In the case of Ft. Ord, the BRAC process began in earnest in July 1991. Initial Army plans were completed in early 1992. The EIS was accelerated to an 18 month schedule and was completed in mid- 1993. The federal screening process was conducted over a six month period in mid-1992. Troops moved during the interval from February 1993 to early 1994. Studies and actual environmental cleanup are ongoing. Initial public benefit conveyances were made to educational institutions in July 1994. It may be another five to ten years before all excess property is transferred. In short, the civilian community must organize and plan for a long, complex process with many changes along the way.

SUMMARY OF COMMUNITY ORGANIZATIONAL RESPONSE

It is critical that the civilian community organize to plan for and respond to the effects of the closure of a military installation. The economy is affected, jobs are lost and the community must plan for recovery. The number of political jurisdictions involved may complicate the recovery process.

In the case of Ft. Ord, the military will retain an enclave of about 1200 acres consisting of housing areas and support facilities. The Bureau of Land Management (BLM) will take over management of approximately 16,000 acres of open space. The State Park system will acquire approximately 850 acres of beach front property. Next, the County of Monterey will have jurisdiction or land use authority over the remaining acres of undeveloped property. The bordering cities of Marina and Seaside will have authority over the Army airfield and almost all developed areas on the installation not retained by the military. This is a result of those cities having annexed the developed areas many years ago with Army concurrence. Although the cities had no jurisdictional authorities, the military population was considered for tax subvention purposes. Next, three other cities (Monterey, Del Rey Oaks, Sand City), having boundaries adjacent to Ft. Ord, have planned various annexations. Also, several other cities are in close proximity to the installation and are affected by the closure process. Finally, the California State University system and the University of California system have been, or will be, deeded approximately 1800 acres of developed property to establish a campus and research facilities.

Three successive community organizations have been responsible for reuse and redevelopment planning:

Ft. Ord Task Force

In January 1990, the Secretary of Defense announced plans to move the 7th Division, and "close" Ft. Ord. Congressman Leon Panetta quickly organized the Ft. Ord Task Force composed of two members of the County Board of Supervisors, eight mayors and three retired military individuals. From early 1990 until the BRAC decisions of July 1991, the focus of the Task Force was to keep the base open.

In the early summer of 1991, Congressman Panetta and the local political leadership redirected the efforts of the Task Force towards reuse and redevelopment planning. The Congressman wanted to have broad based community involvement and input. The Task Force operated on consensus. Seven Advisory Groups were formed to produce a Strategy for redevelopment. One of those advisory groups was tasked to explore issues and recommend strategies relating to Health, Community and Public Services. The organization and role of that group is explained in Chapter 1.

In June 1992, the Ft. Ord Task Force completed its Strategy Report.[3] It formed the basis for the next planning step, the development of a Base Reuse Plan.

Ft. Ord Reuse Group

One of the major recommendations of the Task Force was the creation of a governmental structure which would be responsible for and have authority over development of a Base Reuse Plan. In October 1992, the Ft. Ord Reuse Group (FORG) was formed. It included the County and five cities. A project coordinator was selected and a small staff assembled. The initial draft Base Reuse Plan was published in early 1993. The FORG organization also operated on consensus which led to delays in making decisions on some land use proposals. Updated versions of the Base Reuse Plan were published through May 1994.

Ft. Ord Reuse Authority

For many reasons, efforts were made to develop a permanent organization with decision making authority for the redevelopment of Ft. Ord. After months of negotiations, State legislation was passed creating the Ft. Ord Reuse Authority (FORA) in May, 1994. It continues the work on the FORG Base Reuse Plan and its Board of Directors is responsible for the overall planning and redevelopment.

In summary, it can be seen from the above, that no single organizational body has been responsible for three years of community planning in response to this base closure. However, most of the players have remained the same throughout the process. Moreover, the Strategy Report of the Ft. Ord Task Force and the initial versions of the FORG Base Reuse Plan form the foundation of the plans for FORA.

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[3] *Ibid.*

CHANGES IN HEALTH CARE DELIVERY IN THE FT. ORD AREA

Military Health Care in the Monterey Region[4]

The focal point for military health care in the local area was Silas B. Hays Army Community Hospital (SBHACH). Designed in 1969 and opened in 1972, the hospital replaced the WW-II wooden hospital built in the early 1940s. An 8-story structure of almost 400,000 square feet, the hospital had a full capacity of 440 beds for wartime needs. The hospital commander and his staff were responsible for the overall health care needs of the military beneficiary population of the region. It was the hospital commander's duty to ensure active duty members were in good health, and that the rest of the beneficiaries had access to appropriate care as space and resources permitted. Pertinent definitions are provided in Figure 1.

Department of Defense "Eligible Beneficiaries"- includes active duty military personnel and their family members, and retirees and their family members. All are eligible to use the Military Health Services System (MHSS). Active duty personnel have priority over other beneficiaries, who are served on a "space available" basis.

CHAMPUS Eligible Beneficiaries - includes family members of active duty military, and retirees and their family members who are under the age of 65. The active duty military and those other DoD eligible beneficiaries, 65 and over are not eligible. Those beneficiaries over 65 must seek care through MEDICARE or other private providers.

CHAMPUS Reform Initiative - In 1989, the DoD established a special program in California and Hawaii through a contract with Foundation Health Plan to serve CHAMPUS eligible beneficiaries. The program added two low cost options to the Standard CHAMPUS program - CHAMPUS PRIME and CHAMPUS EXTRA. The contractor established a network of physicians who would accept eligible beneficiaries who elected the program.

TRICARE - STANDARD, PRIME and EXTRA - replaces the previous CHAMPUS Reform Initiative (CRI) programs and began on February 1, 1994. A new contractor (Aetna Government Health Plan) was selected to administer the programs in California and Hawaii.

PRIMUS Clinics - Through contract with the Sisters of Charity, DoD established two clinics in the local area - on Blanco Rd. in Salinas and at the Presidio of Monterey. Operated from the late 1980s to July 1993, these clinics served all eligible DoD beneficiaries on an outpatient basis, including pharmacy service.

Military Treatment Facility (MTF) - Includes military hospitals such as Silas B. Hays, and military clinics such as the Troop Medical Clinic (TMC) previously operated at Ft. Ord. TMCs are outpatient facilities only and primarily serve active duty personnel.

Figure 1 **- Definitions**

Until early 1993, there were approximately 58,000 eligible Department of Defense (DoD) beneficiaries in the Monterey area. The health care delivery system included:

- Silas B. Hays Hospital--provided both inpatient and outpatient care to the eligible population with priority to active duty personnel, and "space available" care to all other eligible DoD beneficiaries.

- Troop Medical Clinic (TMC)--a modern facility that primarily served outpatient needs of the active duty military personnel on base. This clinic was closed in 1993 after departure of major elements of the 7th Division.

[4] *Monterey Regional Health Resources Strategy Study Report*, April 15, 1994, pgs. 1-5.

- PRIMUS Clinics--two outpatient clinics (one located in Salinas and one at the Presidio of Monterey) served outpatient needs of all beneficiaries. These clinics were closed in July 1993.

- Standard CHAMPUS Program--serving beneficiaries electing this fee-for-service health care option.

- CHAMPUS Reform Initiative (CRI)--serving eligible beneficiaries electing this managed care option. CRI included CHAMPUS PRIME and CHAMPUS EXTRA programs administered by Foundation Health Plan under contract to DoD. Each program included a local network of primary care physicians, specialists, and civilian hospitals.

With this health care delivery system, there were several health care sources available to the 58,000 eligible DoD beneficiaries who, in turn, made choices to best suit their needs.

The Transition Period from 1993 to 1994

The period between spring, 1993 and the date of this report was tumultuous for military beneficiaries in the Monterey region. During the period, major changes included:

- Closure of the two PRIMUS Clinics on July 31, 1993.

- Termination of the CHAMPUS PRIME and EXTRA programs with Foundation Health Plan on January 31, 1994.

- Award of a new contract for TRICARE PRIME and EXTRA to Aetna Government Health Plan, with an effective date of February 1, 1994. TRICARE benefits and coverage information are provided at Appendix B.

- Termination of inpatient services at Silas B. Hay Hospital on March 31, 1994.

- Termination of outpatient services and closure of Silas B. Hays Army Hospital on June 30, 1994.

- Resultant shift of eligible DoD beneficiaries to one or more of the following systems:

    - Active duty personnel to the Troop Medical Clinic established at the Presidio of Monterey for outpatient care and to a local civilian community hospital or Military Treatment Facility (MTF) elsewhere for inpatient care.

    - Very limited "space available" outpatient care at the Presidio of Monterey, Troop Medical Clinic for other DoD eligible personnel.

    - TRICARE STANDARD, PRIME or EXTRA programs for non-active duty eligible DoD beneficiaries under age 65.

    - MEDICARE or other private insurance programs for eligible beneficiaries age 65 and over. Figure 2 summarizes the changes in the DoD eligible beneficiary population in the Ft. Ord area between FY92 and FY94.[5]

[5] *Ibid.*, pg. 5.

With this introduction, the study report will now address key issues organized into four major areas of emphasis, and outline lessons learned from the past four years of experience. The report concludes with observations for the future.

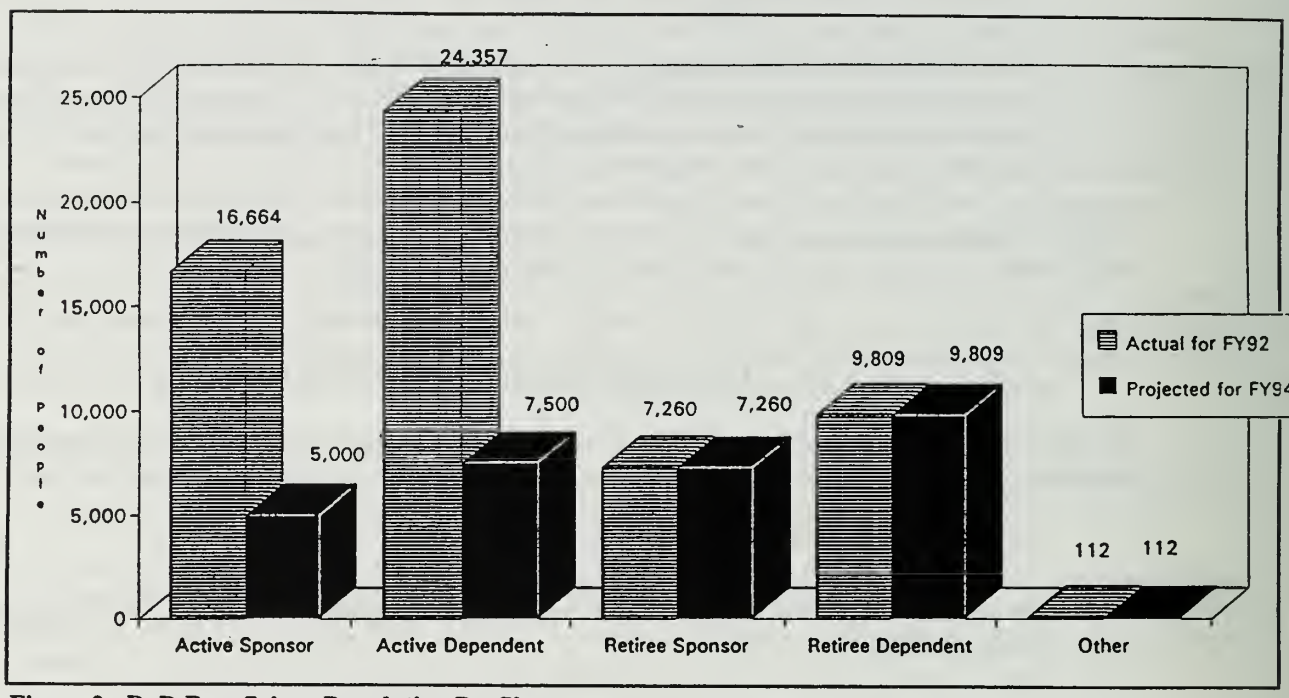

***Figure 2* - DoD Beneficiary Population Profile**

CHAPTER 1

ORGANIZATIONAL RESPONSE

PURPOSE

This Chapter outlines the organizational response of the military hospital and the civilian community to the closure of Silas B. Hays Army Community Hospital (SBHACH). A time line depicting the life span of community organizations is provided in Figure 3. The Chapter concludes with the major lessons learned from the experience of both the military and civilian health care delivery systems and from the perspective of the DoD beneficiaries.

THE CLOSURE OF SILAS B. HAYS ARMY COMMUNITY HOSPITAL (SBHACH)

The U. S. Medical Department Activity (MEDDAC) at Ft. Ord was commanded by an Army Colonel (M.D.). His responsibilities included the SBHACH, medical treatment facilities (MTF) of clinic size on Ft. Ord, at Ft. Hunter-Liggett, and the Presidio of Monterey, area support to 15 counties in central and southern California, and support to reserve components at Camp Roberts, a National Guard installation.

The MEDDAC commander reported directly to the Commander of the Army Health Services Command (HSC) located at Ft. Sam Houston, Texas. Personnel staffing, budgeting, resource management, logistics and all other staff functions were communicated directly between the MEDDAC staff and the HSC staff.

The organization and planning for the closure of the Ft. Ord MEDDAC was accomplished in three main phases as outlined below.

Phase I - July 1991 - July 1992

This phase encompassed planning for the movement of the 7th Division and developing the closure schedule for SBHACH. A detailed analysis was conducted of beneficiary demographics, an inventory of civilian health care resources was completed and alternatives were developed. The MEDDAC established a central point of contact. At the end of this period, the HSC designated the Madigan Army Medical Center (MAMC) in Tacoma, Washington as an intermediate layer in the chain of command between HSC and the MEDDAC at Ft. Ord.

Phase II - July 1992 - July 1993

The second phase involved planning and support for the movement of one-third of the elements of the 7th Division and for inactivation of the remainder of the division. More definite time lines were established for the closure of the hospital and to begin the process of educating beneficiaries and staff.

Phase III - July 1993 - July 1994

During this final phase, the hospital was reduced to a 50 bed facility, then to an outpatient facility and then closed. A Troop Medical Clinic was established at the Presidio of Monterey upon closure of the two

PRIMUS clinics in the local area. A new organization, the California Medical Detachment, Monterey Bay Region was organized to plan for and then assume area responsibility from the MEDDAC. Finally, throughout this period the MEDDAC staff was engaged in the transition from one DoD contractor to another for management of the CHAMPUS TRICARE contract.[6]

From an organizational perspective, the MEDDAC Commander and staff had to coordinate planning and execution of the closure with the following organizations (see Figure 3):

- Health Services Command (HSC). This command provided policy guidance, funding, personnel staffing and reassignment instructions, logistics support, property disposition and all other general guidance to the MEDDAC.

- The Madigan Army Medical Center (Tacoma, Washington) This intermediate command assumed a regional responsibility late in Phase I and became a planning/policy layer between HSC and the MEDDAC at Ft. Ord.

- Commander and staff, Ft. Ord. This command set the time lines for the closure process of the entire installation.

- Civilian Health Care Delivery Systems. During the closure process most DoD eligible beneficiaries remaining in the area had to be shifted to civilian providers and hospitals.

- DoD Contractor for CHAMPUS TRICARE. The contractor was responsible for establishing the network of providers and hospitals to accommodate eligible DoD beneficiaries.

- DoD eligible beneficiaries. This population consisted of 5,000 active duty personnel remaining in the area at DLI and the NPS; 7,500 family members of the above; and 17,000 retirees and family members in the local area.

- Community Reuse/Redevelopment Organization. These organizations (Ft. Ord Task Force, FORG, FORA) developed plans for reuse of property.

- The California Medical Detachment, Monterey Bay Region. This organization was established in August 1993 to plan for and assume area responsibilities of the MEDDAC.

The MEDDAC response to the organizational and planning challenges can be summarized as follows:[7]

- Appointment of a single point of contact and spokesperson early in Phase I.

- Initial planning by the Director of Resource Management (DRM) within the MEDDAC. This paralleled the organizational response of the Ft. Ord commander who focused all planning within the Ft. Ord DRM.

- The expansion of Coordinated Care Division during Phase II to supervise all activities relating to beneficiary disengagement and assignment to either DoD contract systems (CHAMPUS TRICARE) or to MEDICARE.

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[6] U.S Army MEDDAC, Ft Ord, California "*After Action Report*," June 30, 1994, pg. ii

[7] *Ibid.*

- The creation of a BRAC office to assume planning/execution responsibilities of the DRM. This paralleled the organizational changes on the Ft. Ord staff.

- The participation of the MEDDAC Commander in work by the Ft. Ord Task Force. Later, in Phases II and III, the BRAC offices of Ft. Ord and the MEDDAC participated as active members of the Blue Ribbon Committee as discussed below in this Chapter.

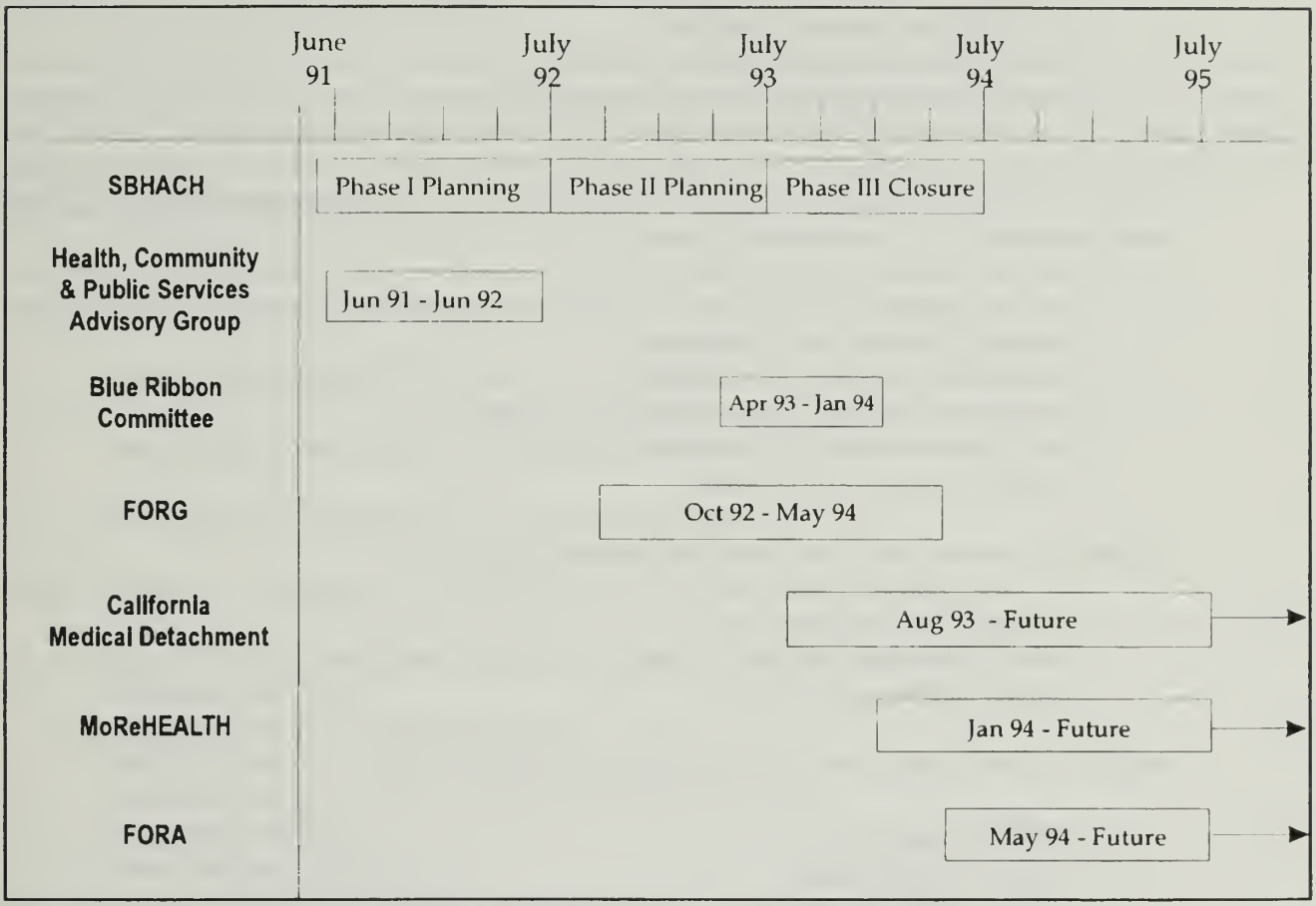

Figure 3 **- Life span of Community Organizations**

THE HEALTH, COMMUNITY AND PUBLIC SERVICES ADVISORY GROUP OF THE FT. ORD TASK FORCE

In June 1991, the leadership of the Ft. Ord Task Force created an organizational framework to develop an overall strategy for the reuse and redevelopment of the installation. Seven citizen-based, volunteer Advisory Groups were established as follows:

- Health, Community and Public Services
- Economic Development
- Education
- Environmental Cleanup
- Housing
- Utilities and Infrastructure
- Land Use

The leadership of the Task Force developed goals and objectives for each of the Advisory Groups and carefully selected chairpersons for each group. The chairpersons were given an initial orientation on July 5, 1991. Over the next 30 - 60 days, they organized their groups, selected volunteer members, and began to develop their plan for the work ahead. The objectives were to:

- Gather relevant information and data
- Measure the impacts of the closure of Ft. Ord
- Develop reuse/recovery concepts
- Develop and evaluate alternatives
- Develop a consensus on recommended alternatives
- Produce a strategy for reuse/recovery

The co-chairs of the Health, Community and Public Services Advisory Group developed an organization which consisted of 119 members as follows:

- Two co-chairs
- Steering Committee of 12 members
- Health Services Panel (29 members)
- Community (Human) Services Panel (28 members)
- Public Services Panel (28 members)
- Specialty advisors (20 members)

The Health Services Panel was divided into three sub-panels:

- Hospital and Ambulatory Care
- Public Health and Preventive Medicine
- Insured and Managed Care

Members on the Health Services Panel included representatives from:

- MEDDAC at Ft. Ord
- Local civilian hospitals
- County Health Department
- County Medical Society
- Dental Society
- DoD Contractor for CHAMPUS PRIME and EXTRA programs
- PRIMUS Clinics
- Retiree organizations

The Health Services Panel conducted numerous meetings throughout the period from September 1991 through June 1992. Frequent progress reports were made to the leadership of the Ft. Ord Task Force in public sessions. In addition, four public forums were conducted.

Prior to organization of the Advisory Groups of the Task Force, there was no single organization which brought together all the health services representatives noted above. Each entity dealt with other entities on an as needed basis. For example, there was no routine association between the MEDDAC and the medical society. The MEDDAC commander and staff did work with local hospitals but usually on a case-by-case basis. Certainly, the MEDDAC did have to deal routinely with the DoD contractor and the PRIMUS clinics.

The report of the Health, Community and Public Services Advisory Group was completed in May 1992. It contained 17 major recommendations and a compendium of future study requirements. In June 1992, when the overall Strategy Report of the Task Force was completed, the Advisory Groups were released, subject to recall on an as required basis.

THE SILAS B. HAYS BLUE RIBBON COMMITTEE

By April 1993, many key issues emerged as the military plans for Ft. Ord were firmed up and the sequential closure of the MEDDAC was announced. The two local area PRIMUS Clinics were scheduled for closure on July 31, 1993 and an increasing number of DoD beneficiaries were required to select replacement health delivery services. The retiree community was especially vocal to the political leadership, the Army and the MEDDAC commander and staff.

As a result, State Senator Mello, then the chair of the Ft. Ord Task Force (having replaced former Congressman Leon Panetta) asked that a Blue Ribbon Committee be formed to:

- Further study the impacts of closure of the MEDDAC
- Address health care needs of the DoD beneficiaries
- Identify how Ft. Ord resources could best be utilized

The Blue Ribbon Committee was organized in May 1993 with representatives from:

- Health Services Panel of the Ft. Ord Task Force
- MEDDAC at Ft. Ord
- DoD contractor for CHAMPUS programs
- PRIMUS clinics
- Local Hospitals (3)
- County Medical Society
- Several Retiree organizations
- Defense Health Resources Study Center (DHRSC)

The full committee met bi-weekly and conducted its work in two phases. In Phase I, the Blue Ribbon Committee, with the assistance of the above organizations, gathered and analyzed data on the impact of the closure of Silas B. Hays Hospital as it related to the needs of the community's DoD beneficiary population. Changes in demographics were projected. The capabilities of a changing health care delivery system were measured against projected needs. Potential problem areas were highlighted and the committee made recommendations for solutions. The results of the Phase I Study were published in October 1993 in the form of a White Paper which was briefed to the Ft. Ord Task Force, the Ft. Ord Reuse Group, and the County Board of Supervisors. The main elements of the White Paper are contained in Chapter 1 of the Monterey Regional Health Resources Strategy, Study Report.[8]

Phase II of the study was begun in late October 1993. The focus of Phase II was three-fold:

- To track and analyze the changes in health care delivery for the eligible military population in the region.

[8] *Monterey Regional Health Resources Strategy Study Report*, April 25, 1994, pg. ix

- To examine the emerging requirements associated with the redevelopment of Ft. Ord as outlined in the FORG Base Reuse Plan.

- To develop principles for a health care strategy addressing needs and opportunities in the region.

These three areas are addressed in Chapters 2-4 of the study cited above. The study was designed to assist the community in recognizing health care needs, and to provide recommendations for appropriate, focused health care for the region as one of the major providers went away. It was also intended to be a catalyst, however, to introduce healthy concepts and ideas to the community as national forces impact health care.

The Defense Health Resources Study Center (DHRSC) was a significant, welcome addition to the Blue Ribbon Committee. DHRSC was formally established in January 1993 at the Naval Postgraduate School (NPS) in Monterey, California. Established for health services research and development, DHRSC operates in the very unusual capacity of a "virtual organization"--a consortium based on strategic alliances, focused on research and information needs of user organizations. All operating funds are generated from valuable work done for clients, making DHRSC a totally cost-reimbursable entity. DHRSC works closely with NPS and the Defense Manpower Data Center (DMDC) in Monterey, the Public Health Service, the Department of Veterans Affairs, and other organizations in both the public and private sectors. The staff of DHRSC provided invaluable assistance to the Blue Ribbon Committee and was instrumental in forming MoReHEALTH.

The Blue Ribbon Committee evolved into the Monterey Regional Health Development Group, Inc. (MoReHEALTH) as described below.

THE MONTEREY REGIONAL HEALTH DEVELOPMENT GROUP (MoReHEALTH), INC.

Phase IV: July 1994 - Future

Based on a Health Direction Summit sponsored by the Blue Ribbon Committee in October 1993, the regional participants saw the need for a more permanent organization to bring together the many representatives of the health services community. As a result, the MoReHEALTH Group was organized and chartered as a non-profit, 501 C(3) corporation in January 1994. This organization took over the work of the Blue Ribbon Committee once the Regional Health Resources Strategy was completed.

The Board of Directors of MoReHEALTH consists of many of those on the Ft. Ord Task Force and the Blue Ribbon Committee, and are top policy-makers from the member organizations. Additional members were added to represent business, labor, and community organizations. The Executive Committee is composed almost entirely of members from the original organizations.

Mission of MoReHEALTH

The mission of MoReHEALTH is to focus on coordinated community health strategies that:

- Identify and implement initiatives to address health and health care needs emerging from the closure of Ft. Ord;

- Bring a regional perspective to the area's health care resources;

- Bring a strong voice of advocacy for addressing the health of under-served and unserved individuals in the region; and,

- Act as a major proponent for health promotion and education of the region's population.

Facts Bearing on the Mission

- An initial focus, and need for action, is with the area's military beneficiary population;

- Resolution of the mission objectives are local responsibilities;

- There is a unique opportunity amidst change for positive action in the health care environment today; and,

- Health preservation and care are vital issues that can significantly strengthen the local economy.

Specific projects of MoReHEALTH are as outlined below. In effect, the organization continues to work on areas related to the closure of the MEDDAC at Ft. Ord while looking to the future health care needs of the entire community.

Projects of MoReHEALTH

- In conjunction with Defense Health Resources Study Center (DHRSC), gathering and collating the lessons learned from the closing of Silas B. Hays Army Community Hospital (this report).

- Monitoring the DoD's managed-care contract for adequacy of care to the DoD beneficiary population.

- Designing and executing a health beneficiary survey for the Monterey region to obtain baseline data regarding retiree health care needs.

- Providing consulting services to the Ft. Ord Reuse Authority to help design a strategy to deliver health care to new populations at Ft. Ord.

- Facilitating the establishment of a Veterans Administration Outpatient Medical Clinic at the Presidio of Monterey Annex (formerly Ft. Ord) for eligible veterans and possibly for other individuals through resource-sharing arrangements with other sponsors.

- Promoting a Continuum of Care Retirement Community (CCRC) project to be developed on Ft. Ord properties for moderate income elderly.

- Sponsoring, with local Chambers of Commerce, public forums on health issues, such as the single-payer health plan proposal which was decided by the California electorate in November 1994.

- Coordinating the assessment of regional community health care needs and satisfaction.

CALIFORNIA MEDICAL DETACHMENT, MONTEREY BAY REGION

Background

The California Medical Detachment (CMD), Monterey Bay Region was established in August 1993 by the U.S. Army Health Services Command to provide regional command and control of 6 geographically separate Army health and occupational medicine clinics remaining in northern California and western Nevada. The CMD is under the control of the Northwest Health Services Support Area located at Madigan Army Medical Center at Ft. Lewis, Washington.

The CMD assumed control over the Troop Medical Clinic at the Presidio of Monterey in August 1993. Then, it assumed control over the other 5 clinics in its geographic area during the remainder of 1993, and the first half of 1994.

Mission of CMD

A primary mission of the CMD in the Monterey region is to provide medical care for the approximately 5,000 active duty personnel assigned to the Defense Language Institute (DLI) and the Naval Postgraduate School (NPS) remaining in the base closure area. This care is provided on an outpatient basis through the Troop Medical Clinic at the Presidio of Monterey and through contracts with local specialty providers. Inpatient care is provided either through the nearest military hospital (Oakland Naval Hospital or Travis AFB) or through arrangements with local hospitals.

Another mission of the CMD is to assist in the coordination of health care delivery for family members of active duty personnel (approximately 7,500) through the CHAMPUS TRICARE programs. It also assists in coordinating the TRICARE programs for eligible retirees and their family members (under 65 years of age) and the MEDICARE program for retirees and their family members (65 years of age and over).

The CMD is located at the Presidio of Monterey Annex (formerly Ft. Ord) and its headquarters and Coordinated Care Division are co-located with the TRICARE Service Center operated by Aetna, the managed-care contractor. The mission statement of the California Medical Detachment, Monterey Bay Region is at Appendix C.

THE BRAC BENEFICIARY WORKING GROUP

In September 1993, the BRAC Beneficiary Working Group (BBWG) visited Ft. Ord, the local military commanders and members of the local communities. This congressionally mandated sensing group was tasked to visit base closure sites, gather information and report back to Congress. The visit was very late in the overall closure process for Ft. Ord and the MEDDAC. The local area retirees who participated in the BBWG visit sensed that the group had no ability to take action on key issues or to change anything.

FEDERAL RESPONSE TO HOSPITAL CLOSURE

Except for the short visit of the BBWG noted above, the local community organizations planning for changes resulting from the closure of the Ft. Ord Hospital could detect no coordinated effort at the federal level to provide guidance or assistance. Certainly, the local MEDDAC staff and the local representative for the DoD managed-care contractor did participate in the planning efforts for the community. However, over time, there was a need to coordinate plans with:

- DoD for disposition of medical related property and equipment;
- DoD for future changes in the managed care contract program options;
- The Department of Veterans Affairs for potential delivery of health care services;
- The Department of Health and Human Services for public benefit conveyances of property to be used for health care delivery; and,
- The Health Care Finance Administration regarding disengagement of DoD beneficiaries from military health care to MEDICARE.

LESSONS LEARNED - ORGANIZATIONAL RESPONSE TOPICS

Topic 1-1: Military

Discussion: The MEDDAC at Ft. Ord adjusted its organization to fit changing needs. Initial planning was done by the DRM. Then, a BRAC office was established. The Coordinated Care Division was expanded to manage all disengagement activities. At mid-stream an extra coordinating layer was inserted between the Ft. Ord MEDDAC and HSC. Finally, the California Medical Detachment was created to assume responsibilities of the MEDDAC.

Lesson Learned: Although the MEDDAC at Ft. Ord made internal organizational adjustments to meet changing requirements, there were external changes in reporting channels and delays in arriving at a follow-on organization to assume the responsibilities of the MEDDAC. These changes caused delays in policy guidance and response to pressing issues. There now exist an adequate number of hospital closure experiences to develop a clear organizational model.

Recommendation: Do not change organizational reporting channels during the closure process. From the lessons learned at the MEDDAC at Ft. Ord and other closures (such as at Letterman Army Medical Center in San Francisco), develop a firm organizational scheme and stick with it.

Topic 1-2: Civilian/Military Coordination

Discussion: Closure of the MEDDAC necessitated major changes in the health care delivery system for approximately 30,000 eligible personnel remaining in the Ft. Ord area. It is the civilian health care system which had to absorb these extra demands through DoD managed care programs (TRICARE) or MEDICARE. Of necessity, the military must coordinate this change with the civilian sector.

Lesson Learned: Early on in the base closure process, an organization was required to coordinate both military and civilian health care delivery systems. The organization included all key players in the process such as: military hospital commander and staff, civilian hospitals, medical society, DoD contractor and retirees.

Recommendation: Based on the Ft. Ord experience and other hospital closures, DoD and the military departments should provide organizational guidance for future closure sites. That guidance must include pro-active coordination with the DoD contractor, the civilian health care delivery system and DoD eligible beneficiaries.

Topic 1-3: Civilian Community

Discussion: In the Ft. Ord area, three successive organizations were formed to provide for planning and coordination of health care delivery associated with the closure of the MEDDAC. The first two of these organizations were responsive to the Ft. Ord Task Force. The third (MoReHEALTH) is independent of, but works in coordination with the Ft. Ord Reuse Authority. The key members of all three organizations have remained the same. In addition to planning and coordinating changes in health care delivery, all three organizations have dealt with future reuse of medical facilities and medical equipment which have become excess.

Lesson Learned: Changes in the organizations over time have caused some lack of continuity in planning and response to changes. Moreover, the community organization responsible for overall base reuse planning needs advice on changes in health care delivery, future use of facilities/equipment, and health care delivery to support the base reuse plan.

Recommendation: If at all possible, create or empower a civilian organization with credible and respected, key leadership, which is empowered to provide coordination between the military and civilian medical system, and advise and assist the base reuse planning organization through the entire planning and redevelopment process.

Topic 1-4: Funding Support for Planning and Execution

Discussion: Funding resources are required to ensure professional planning by the military, development of baseline data on the beneficiary population, publication of informational packets, provide for follow-up surveys on beneficiaries after closure, and to assist the community planning organizations prior to, during, and after a hospital closure. Funds were eventually provided to SBHACH for informational packets, but late in the process. The Blue Ribbon Committee was fortunate to get grant funds from the DoD Office of Economic Adjustment (OEA) to complete its studies. Otherwise, no funds were available from DoD.

Lesson Learned: Both the closing military hospital and the civilian planning organizations needed funding support for early planning through post-closure operations in order to ensure continuity of care.

Recommendation: DoD provide funds to cover costs associated with planning and execution.

Topic 1-5: BRAC Beneficiary Working Group (BBWG)

Discussion: This group visited the military and civilian organizations in the area and gathered input from beneficiaries to include retirees.

Lesson Learned: The BBWG visit (September 1993) was too late in the closure process by about 1-2 years. Then, the BBWG did not have adequate authority to make any changes.

Recommendations: If the BBWG is continued with the 1995 base closure round, send it out early in the planning process and give it the authority to take action.

Topic 1-6: Federal Response to Hospital Closure

Discussion: The local community organizations dealing with a military hospital closure eventually must coordinate planning efforts with several federal agencies responsible for various aspects of health care delivery.

Lesson Learned: While DoD is the primary agency involved in the base closure and redevelopment process, other federal agencies play key roles in matters relating to health care and reuse planning.

Recommendation: The DoD should take the lead among federal agencies to provide coordinated guidance and assistance to local community organizations dealing with a base and hospital closure. As a minimum, this should include the Department of Veterans Affairs, the Department of Health and Human Services, and the Health Care Finance Administration.

CHAPTER 2

INFORMATION AND EDUCATION

PURPOSE

This Chapter outlines the information and data required by both military and civilian planners as closure plans are developed. Then, the military hospital staff, civilian health care providers, the DoD contractor and DoD beneficiaries must be educated on the closure plan and transition to alternative delivery systems.

INFORMATION

Hospital Catchment Area

Normally, a MEDDAC catchment area is defined as an area extending 40 miles from the hospital. In the case of the hospital at Ft. Ord, such an area would not encompass the outlying clinic at Ft. Hunter-Liggett and support delivered to active duty and reserve component personnel at Camp Roberts. As a result, some adjustments are required when developing catchment area data.

Early on in the planning process, the staff at the MEDDAC began to develop planning data. Both military and civilian planners needed to know:

- How many DoD eligible beneficiaries are within the planning area?
- How many active duty beneficiaries and family members will depart the area due to the base closure? What will be the phasing of those departures?
- How many DoD beneficiaries will remain in the planning area (active duty and family members plus retirees and family members)?
- How many beneficiaries remaining in the area are under 65 and how many are 65 and over?
- How many beneficiaries remaining use the MEDDAC, PRIMUS CLINIC, CHAMPUS program?
- How many retired beneficiaries have second careers and now are covered by a non-DoD employer program?

The MEDDAC at Ft. Ord established a central point for development of data to attempt to answer the above questions. Early on in 1991-1992, several inadequacies were found in data sources. The Defense Eligibility Enrollment System (DEERS) is a key source for determining those that are DoD eligible. However, address data, especially for retirees, were frequently incorrect. Similarly, address data in the AQCESS[9] database were inadequate. The best attempt was made to develop data such as shown in the Introduction, Figure 2. However, there was always lingering concern that the data could have been more exact.

[9]DoD Automated Quality of Care Evaluation Support System (AQCESS).

MEDDAC Inpatient/Outpatient Data

An essential planning step is to determine the inpatient/outpatient requirements which will be shifted from the closing MEDDAC to other health care systems such as CHAMPUS TRICARE or MEDICARE. The MEDDAC staff developed information based on FY92 experience and then projected forward to FY94 when the MEDDAC would be closed. Examples of the inpatient information is shown in Tables 1 and 2.[10]

Similar data were developed on outpatients as shown in the Figures 4 and 5 below.[11]

CAPACITY OF CIVILIAN HEALTH CARE SYSTEM

From the data developed by the MEDDAC, the civilian planning organizations described in Chapter 1 determined the capacity of the civilian health care system necessary to absorb the DoD beneficiaries. An example is shown in Table 3.[12]

The civilian planning organization then determined that the local hospitals had adequate inpatient capacity to absorb the projected requirements of the shift of DoD beneficiaries. An examination was also made of the number of physicians by specialty to determine if there were adequate numbers available to meet expected needs.

Table 1 **-Silas B. Hays Inpatient Days by Service by Personnel Category (Fiscal Year 1992)**

	Active Dependent		Active Sponsor		Retiree Dependent		Retired Sponsor		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Internal Medicine	532	2.0	944	3.6	1,787	6.8	2,424	9.0	35	0.0
Gastroenterology	0	0.0	25	0.0	0	0.0	0	0.0	0	0.0
Intensive Care Unit	26	0.0	26	0.0	116	0.0	165	1.0	5	0.0
Neurology	18	0.0	15	0.0	4	0.0	2	0.0	0	0.0
General Surgery	392	1.5	755	2.9	562	2.1	835	3.2	12	0.0
Oral Surgery	62	0.0	698	2.7	5	0.0	2	0.0	0	0.0
Ophthalmology	20	0.0	18	0.0	22	0.0	66	0.0	0	0.0
Ear, Nose & Throat	160	1.0	162	1.0	37	0.0	32	0.0	2	0.0
Urology	61	0.0	200	1.0	26	0.0	203	1.0	0	0.0
Gynecology	458	1.7	167	1.0	147	1.0	5	0.0	5	0.0
O.B./Labor & Delivery	4,242	16.1	866	3.3	70	0.0	0	0.0	50	0.0
Pediatrics	1,467	5.5	0	0.0	41	0.0	0	0.0	6	0.0
Nursery	3,072	11.7	0	0.0	16	0.0	0	0.0	148	0.0
Orthopaedics	151	1.0	2,077	7.9	62	0.0	183	1.0	6	0.0
Podiatry	47	0.0	117	1.0	6	0.0	5	0.0	0	0.0
Psychiatry	405	1.5	1,658	6.3	175	1.0	111	0.0	0	0.0
SUBTOTAL	11,113	44.0	7,728	30.7	3,076	10.9	4,033	15.2	269	0.0

Source: Based on AQCESS data for Fiscal Year 1992

[10] *Monterey Regional Health Resources Strategy Study Report*, April 25, 1994, pgs 6 & 7

[11] *Ibid*, pgs 9 & 10

[12] *Ibid.*, pg. 8

Table 2 - **Projected Annual Inpatient Days for Monterey County by Health Service by Personnel Category**

	Active Dependent		Active Sponsor		Retiree Dependent		Retired Sponsor		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Internal Medicine	166	1.26	287	2.17	1,787	13.53	2,424	18.35	35	0.27
Gastroenterology	0	0.0	8	0.06	0	0.0	0	0.0	0	0.0
Intensive Care Unit	6	0.05	8	0.06	116	0.88	165	1.25	5	0.04
Neurology	3	0.02	5	0.04	4	0.03	2	0.01	0	0.0
General Surgery	124	0.94	228	1.73	562	4.23	835	6.32	12	0.09
Oral Surgery	29	0.22	211	1.60	5	0.04	2	0.01	0	0.0
Ophthalmology	5	0.04	6	0.05	22	0.17	66	0.50	0	0.0
Ear, Nose & Throat	49	0.37	48	0.36	37	0.28	32	0.24	2	0.01
Urology	21	0.16	49	0.37	26	0.20	203	1.54	0	0.0
Gynecology	145	1.09	48	0.36	147	1.11	5	0.04	5	0.04
O.B./Labor & Delivery	1,339	10.14	263	1.99	70	0.53	0	0.0	50	0.38
Pediatrics	465	3.52	0	0.0	41	0.31	0	0.0	6	0.05
Nursery	966	7.31	0	0.0	16	0.12	0	0.0	148	1.12
Orthopaedics	49	0.37	627	4.75	62	0.47	183	1.39	6	0.05
Podiatry	14	0.11	35	0.27	6	0.05	5	0.04	0	0.0
Psychiatry	127	0.96	498	3.77	175	1.33	111	0.84	0	0.0
SUBTOTAL	3,508	26.6	2,321	17.58	3,076	23.29	4,033	30.53	269	2.05

Source: Extrapolations based on AQCESS data for Fiscal Year 1992

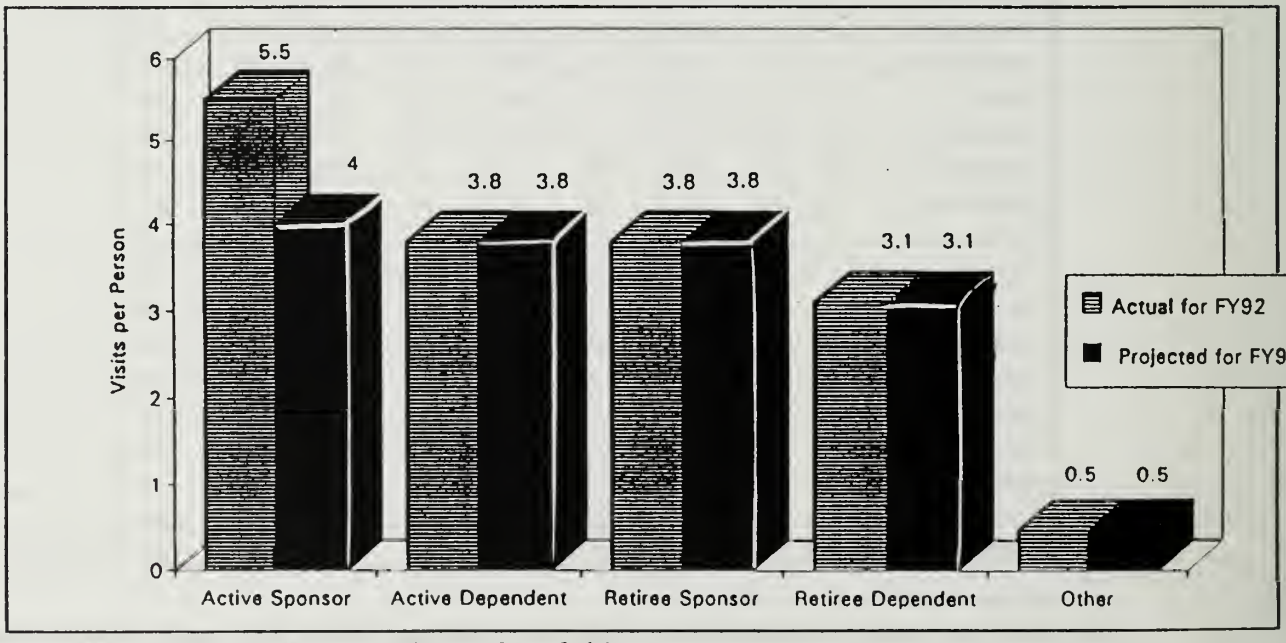

Figure 4 - **Outpatient Visit Profile (by number of visits)**

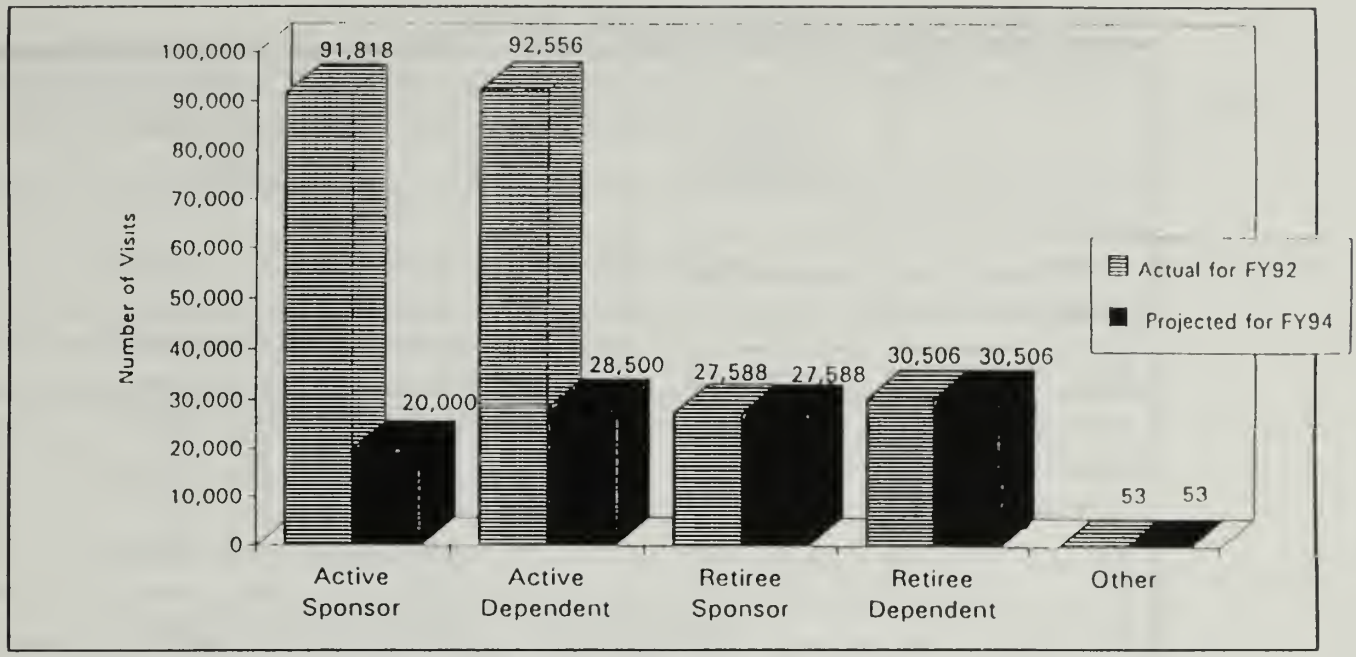

Figure 5 - **Outpatient Visit Profile (by visits per beneficiary)**

Medical Facilities and Equipment

Planning for base reuse and redevelopment must include medical and dental facilities and the equipment in those facilities. The equipment is termed "personal property."

The civilian planning organizations needed all available data on the facilities early in the closure process. The hospital at Ft. Ord is an eight floor building of 400,000 square feet. The question to be addressed was whether the facility should be converted to civilian use. Critical to the analysis was determining if the hospital would meet state seismic standards plus other code requirements. Examination showed that converting the military hospital would require approximately $60 million for seismic, OSHA, electrical and mechanical upgrades. That fact, plus the ability of the civilian hospitals to absorb expected inpatient requirements after the closure, did not justify a conversion to civilian use as an inpatient facility.

Data on the Ft. Ord Troop Medical Clinic (TMC) and three dental clinics were also developed for future planning purposes. However, there was uncertainty throughout the base reuse planning process as to the military's plans to retain or dispose of those facilities. That complicated reuse planning for the civilian community.

As required, the MEDDAC made an inventory of all equipment. On closure of facilities, some equipment is shipped to other military installations where needed. This is particularly true for the more modern equipment. The remainder of the equipment can be transferred with the facility to the civilian organization which takes ownership. Otherwise, the "excess" equipment is sent to the nearest DoD disposal site for sale.

It is important for the community reuse planning organization to identify equipment needs which will mesh with facility reuse plans. The recent provisions of the Pryor Amendment and supporting DoD regulations provide more flexibility for facility and equipment transfer to the gaining civilian reuse organizations.

Table 3 - **Monterey Bay Area Profile of Hospital Utilization**

	COMMUNITY HOSPITAL OF MONTEREY PENINSULA	NATIVIDAD MEDICAL CENTER	SALINAS VALLEY MEMORIAL HOSPITAL	TOTAL
BEDS				
Licensed	176	211	232	619
Available	174	166	220	560

HOSPITAL SERVICES	Beds	Occup Rate	Beds	Occup Rate	Beds	Occup Rate	Total	
MED SURG	122	87.1%	92	26.2%	171	70.8%	385	65.3%
PERINATAL	14	78.4%	14	93.3%	24	49.2%	52	68.9%
PEDIATRIC	6	51.7%	19	38.9%	16	32.6%	41	38.3%
ICU	5	52.4%	8	57.9%	5	67.3%	18	59.0%
CCU	5	68.7%	4	00.0%	16	40.6%	25	39.7%
ICNN	4	79.2%	0	00.0%	0	00.0%	4	79.2%
ACUTE PSYCH	20	64.1%	22	58.1%	0	00.0%	42	61.0%
LNG TERM CARE (SN)	0	00.0%	52	94.9%	0	00.0%	52	94.9%
TOTAL	176	80.0%	211	52.8%	232	64.1%	619	65.0%

BIRTHS				Total
Deliveries	1,642	2,268	1,754	5,664
Well Baby Days	3,722	4,825	3,333	11,880

SURGICAL SERVICES				
Suites	10	3	8	21
Procedures:				
Inpatient	3,642	1,662	4,268	9,572
Outpatient	3,693	795	3,434	7,922
Special Operations				
CV w/Bypass	0	0	173	173
Cardiac Caths	0	0	1,390	1,390

EMERGENCY MED SVC				
Stations	10	5	12	27
Visits:				
Non-Urgent	11,659	13,404	18,084	43,147
Urgent	20,727	1,472	11,256	33,455
Critical	389	1,019	341	1,749
TOTAL	32,775	15,895	29,681	78,351

Average Stay (Days)	4.8	6.8	4.3	5.1
Average Census (Per Day)	142	111	146	399

Outpatient Visits	137,632	112,833	47,647	298,112

Source: Office of Statewide Health Planning and Development, Annual Report of Hospitals, 1991

Users of Information and Data

All users of the essential information and data must cooperate to insure timely access for planning. In the closure of the Ft. Ord MEDDAC, those users included the:

- MEDDAC;
- DoD contractor responsible for CHAMPUS TRICARE managed-care program;
- Civilian health care planning organizations;
- Civilian organization responsible for base reuse planning;
- Local hospitals and physicians;
- DoD beneficiary population; and,
- Defense Health Resources Study Center (DHRSC).

EDUCATION

Education becomes a critical element in planning for and closing a military hospital. The military staff will be reassigned. Civilians on the hospital staff will lose their jobs. DoD beneficiaries will be shifted to other health care programs. The civilian health care delivery system will experience the loss of a neighbor and be asked to take on additional requirements.

The Hospital Staff

Closure planning by the MEDDAC staff included the education of both the military and civilian staff members. The development of a Medical Services Action Plan (MSAP) helped to focus all elements on the plan for closure, time lines and other details. An excerpt of the MSAP is provided at Appendix D.

Concurrently, the MEDDAC appointed a spokesperson to relate information to the affected communities. The hospital staff was updated as required throughout the planning and closure process. It is important to note that the staff relates directly to patients and must be careful to provide correct information. Rumor control is essential.

The Personnel Division of the MEDDAC and the Civilian Personnel Office (CPO) were heavily engaged in determining requirements for the downsizing process and in educating military and civilian staff on policies, procedures and expected time lines for reassignment or layoff. All this had to be closely coordinated with each department, service or division of the hospital.

The MEDDAC staff must also take on the responsibility to educate DoD beneficiaries, the DoD contractor for CHAMPUS TRICARE, and the health care providers in the civilian community. In the case of the MEDDAC closure at Ft. Ord, there were no previously established communication or coordination links between the military and civilian sector.

The DoD Beneficiary Population

The closure of a military installation generates considerable trauma for those DoD beneficiaries remaining in the closure area. Without question, *the closure of the hospital ranks highest on the list of concerns* as compared to other losses such as a Post Exchange (PX), commissary, golf course or other facilities. The retiree population, in particular, is most upset. Many individuals retired in the closure area because of the military hospital. By and large, that hospital always took care of them. Most believed that they had been promised lifetime care by the military. While those under 65 years can change to CHAMPUS TRICARE programs with some out-of-pocket expense, those 65 years and over feel they are being abandoned by being placed in the MEDICARE system. The challenge to the MEDDAC staff, the DoD contractor, and to the civilian planning group is to educate the DoD beneficiaries with accurate and coordinated information.

The MEDDAC program at Ft. Ord consisted of several educational programs as outlined briefly below:

- Publication of relevant information in the Ft. Ord and local press
- Publication and distribution of flyers at the hospital, commissary and PX
- Beginning in 1993, the conduct of a daily briefing by the Coordinated Care Division at the hospital. This briefing explained options available and included steps to disengage from hospital care to a replacement program.
- The conduct of three "Health Fairs." The first two were organized to attract retirees, with the first being relatively unstructured and the second structured to have informational briefings and handouts. The third "fair" was conducted for the active duty and family members assigned to the NPS. Approximately 7,500 attended the first two fairs and 1500 attended the third.
- Publication of a brochure for beneficiaries once funding was obtained ($10,000).[13]

The DoD Contractor for CHAMPUS TRICARE

The DoD contractor must direct attention and resources to educating two audiences. The first is the DoD eligible population which will be disengaged from care at the military hospital to the CHAMPUS TRICARE programs. This group includes the family members of active duty personnel and retirees and family members under age 65. A CHAMPUS TRICARE service center located in the military hospital performed much of this task in conjunction with the Coordinated Care Division. Booklets, pamphlets and applications were available and informative. Network provider listings were updated frequently.

The DoD contractor must also plan for, and then expand the existing provider network plus undertake contract arrangements with local hospitals. All the individual providers must be educated along with their staffs, particularly on matters of referrals to specialists, billing systems and understanding not only the options available to patients, but what their benefits really are. Hospital CEOs and staffs must be educated in a similar manner. Getting busy doctors and staffs to attend briefings or read contractor educational material takes considerable effort.

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[13] U.S. Army MEDDAC, Ft. Ord, California "*After Action Report*," June 30, 1994, pg. 54.

Civilian Health Care Providers and Hospitals

As noted above, the DoD contractor did most of the education for civilian providers and staffs. Prior to the closure announcement, the MEDDAC had no routine organizational contacts with the civilian health care providers or the hospitals (except on a case-by-case basis). The community health care planning organizations (Ft. Ord Task Force Advisory Group, Blue-Ribbon Committee, and MoReHEALTH) did provide a significant interface for education of all parties concerned. The planning organizations included key members of the Medical Society and the CEOs of hospitals who assisted in the education process. The planning organizations also provided a forum for all parties to discuss issues, ask questions and get answers to the same.

LESSONS LEARNED - INFORMATION AND EDUCATION

Topic 2-1: DoD Beneficiary Information

Discussion: Developing an accurate database is essential for planning purposes. While the DEERS accuracy has improved to about 90% since 1991-1992, there are several alternative sources for data such as through the DoD Finance system, retiree newsletters, retiree organization address lists and others.

Lesson Learned: Considerable effort was expended to develop beneficiary information. There were inadequacies in the DEERS and AQCESS systems.

Recommendations: Continue to improve DEERS and AQCESS reliability. Access other DoD and retiree organization databases to obtain the most accurate data at the earliest date possible.

Topic 2-2: Health Care System Used by DoD Beneficiaries

Discussion: Early in the planning process it is valuable to ascertain what health care system the eligible beneficiaries are using. In the Ft. Ord MEDDAC example, planners could not accurately determine those serviced for outpatient care through the hospital, PRIMUS clinic, CHAMPUS, MEDICARE or a civilian program. The same held true for inpatient care options.

Lesson Learned: Accurate baseline data are essential to good planning.

Recommendation: Conduct a survey of the DoD eligible beneficiaries to determine how health care is being delivered prior to downsizing and closure of the hospital. Establish baseline data from which to project and measure changes over time.

Topic 2-3: Facility and Equipment Data

Discussion: During the reuse planning process, the civilian planning organizations asked for and received data on the hospital building from the MEDDAC and installation engineers. The data were needed to determine use of the hospital for civilian reuse. Later in the planning process, data were developed on the Troop Medical Clinic and dental clinics. The information on equipment was requested when it was learned that the military was moving/disposing of the equipment.

Lesson Learned: Civilian reuse plans must be developed more readily and plans made for reuse before equipment is transferred or disposed of through the DoD disposal process.

Recommendation: Both the hospital staff and the civilian organizations involved in a base closure must cooperate on sharing data on all facilities and equipment.

Topic 2-4: Military Role in Educating DoD Beneficiary Population

Discussion: Publicity, media announcements, health fairs and daily briefings at the Ft. Ord MEDDAC all contributed to educating the beneficiary population and even the civilian health care network.

Lesson Learned: The MEDDAC commander and staff must be pro-active in educating the beneficiaries, especially retirees who may be very vocal during the closure process.

Recommendation: An added dimension to the education process would be a direct mailing to the affected beneficiaries and commitment of funds for the effort at "personal contact."

Topic 2-5: Structure of Health Fairs

Discussion: The first health fair was relatively unstructured. A large number of civilian health care delivery organizations were represented with attractive material to encourage DoD beneficiaries. While present at the first fair, the DoD contractor and the MEDDAC were almost in the position of being competitors for business. The second health fair was much more structured with repetitive briefings by the MEDDAC on the closure schedule, disengagement options and guidance.

Lesson Learned: Many of the retired population were confused at the first health fair. Those over 65 were especially distracted as to the various options for care and number of HMO's.

Recommendation: Structured presentations by the MEDDAC with backup written material are superior to unstructured events for educating the beneficiary population.

Topic 2-6: Important Role of DoD Contractor

Discussion: During the education process, the contractor worked closely with the health planning organization and maintained a service center in the Ft. Ord Hospital. Brochures and other material outlined the CHAMPUS (later TRICARE) PRIME and EXTRA programs.

Lesson Learned: The DoD contractor must be pro-active in educating all eligible beneficiaries (under 65). This requires funding to expand what otherwise would be routine operations.

Recommendations Ensure funding is made available to the DoD contractor to promote educational programs. DoD should stipulate that the managed care contractor establish a "member services" function to provide beneficiary advocacy.

Topic 2-7: Coordination of Educational Programs

Discussion: Of necessity, the military and civilian health care delivery systems, the DoD contractor and retiree organizations all share in the education of health care deliverers and beneficiaries.

Lesson Learned: The civilian organizations (Ft. Ord Task Force, Blue-Ribbon Committee, and MoReHEALTH) assisted all parties and contributed to the education process.

Recommendation: Use the local coordinating organization to help develop and coordinate education programs. This effort must be funded with assistance from the federal government.

CHAPTER 3

TRANSITION AND CLOSURE

PURPOSE

This Chapter outlines many of the major events during the transition and closure of the hospital at Ft. Ord. The transition period extended over twelve months from June 1993 to June 1994. Major events during that period included:

- Closure of two local area PRIMUS clinics on June 30, 1993.
- Opening a Troop Medical Clinic at the Presidio of Monterey in August 1993.
- Reduction of hospital inpatient beds to 50 in July 1993.
- Expansion of CHAMPUS PRIME and EXTRA provider network by DoD Contractor-Foundation Health Plan (FHP).
- Reduction in hospital specialty services/clinics beginning in September 1993.
- Specialty inpatient beds closed in November 1993.
- Emergency Room reduced to Acute Care Clinic in December 1993.
- Change in DoD contractor from FHP to Aetna in February 1994. (Name of CHAMPUS PRIME and EXTRA program options changed to TRICARE PRIME and EXTRA.)
- Hospital inpatient services terminated in March 1994. Hospital (SBHACH) converted to an Army Health Clinic.
- Closure of hospital on June 30, 1994.
- Area responsibilities transferred to California Medical Department (CMD), Monterey Bay Region between August 1993 and June 1994.

PRIMUS CLINICS

Two PRIMUS Clinics had been in operation in the Ft. Ord area for several years. The first was located at the Presidio of Monterey (POM). It provided outpatient and pharmacy service to all DoD eligible personnel (active duty, their family members, retirees and their family members). The second clinic was located in the city of Salinas and serviced all DoD eligibles in that area. The PRIMUS Clinics were a DoD contract operation with the Sisters of Charity. Only a valid military ID card and registry in the DEERS system were required to use the clinic. There were no charges to the beneficiaries. Specialty care was referred to the hospital at Ft. Ord, as was inpatient care.

Of primary concern for the MEDDAC commander and staff was the care of the active duty personnel assigned to the DLI and NPS, who would remain in the area. Most used the PRIMUS Clinic at the POM.

That clinic had a greater workload than the PRIMUS Clinic in Salinas. Then, with the departure of the 7th Division, the number of DoD eligibles in the Salinas area would be dramatically reduced. After analysis, the MEDDAC and HSC concluded that the PRIMUS Clinics would be closed on July 31, 1993 and that a Troop Medical Clinic (TMC) would be established on August 1, 1993 at the site of the PRIMUS Clinic at the POM. The TMC would be sized to service the active duty personnel at the DLI and NPS.

These actions in mid-1993 caused a significant number of DoD eligible beneficiaries to change their source of health care to the CHAMPUS STANDARD, PRIME and EXTRA programs or to MEDICARE (if 65 or over). Many delayed their decision and reverted to care at the hospital at Ft. Ord. Major areas of concern for beneficiaries during this period included:

- Finding a new source for health care which would remain stable after the closure of the hospital.

- Selecting a new Primary Care Manager which would accept DoD eligible personnel.

- The ability of the managed care contractor to expand its CHAMPUS PRIME and EXTRA provider network and to establish contracts with local area hospitals.

- The change from DoD health care programs to MEDICARE programs for those 65 and older.

Of note, the County Hospital (Natividad), took over the PRIMUS Clinic facility in Salinas about 60 days after the clinic closed. There, the physicians and nurses from PRIMUS were hired to staff the new clinic which accepted patients from all CHAMPUS programs, and MEDICARE.

HOSPITAL DOWNSIZING

The MEDDAC commander and staff continued to update and change their plans throughout the period as required. Changes in the scheduled downsizing of the 7th Division prompted delays in the termination of some services. Concurrently, efforts were made to stabilize the reassignment of military personnel to accommodate the schedule. Some civilian staff members found other jobs or were reassigned elsewhere when opportunities arose. The "After Action Report" of the Ft. Ord MEDDAC outlines the details of the downsizing process.[14]

The Coordinated Care Division (CCD) was the focal point for the disengagement of DoD beneficiaries. Daily briefings were conducted. Disengagement was accomplished along three tracks:

- Track One: Those patients who had some type of supplemental care or other insurance and already had a local provider. They were disengaged after their CHAMPUS/MEDICARE orientation.

- Track Two: Those patients who had another alternative support program, but who required extra time and assistance in disengagement.

- Track Three: Those patients who generally had long term, chronic problems and were solely dependent upon the military health services system. They were identified early on and were assigned to Nursing Case Managers (NCM). The NCM would work with the patients to insure that health needs were properly identified, a source of care found in the civilian community and records forwarded to the new source of care.

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[14] *Ibid.*

As reported in the MEDDAC's "After Action Report,"[15] some beneficiaries delayed decisions on changing their source of health care. There were rumors that somehow the hospital would be "saved." Efforts to convert the hospital to a Uniformed Services Treatment Facility (USTF) had been explored by the local Congressman but proved to be strongly opposed by both DoD and key congressional committees. Even after disengaging from care through the military hospital, a few beneficiaries sought ways to reenter the system. Finally, some departments within the hospital "held on" to patients in order to stay busy.

Disengagement of beneficiaries 65 and over also meant disengagement from the DoD health care system. Most beneficiaries in this category felt that they had been abandoned by the military. They cited promises of lifetime care. Transition to MEDICARE meant additional out of pocket costs. A significant number had not elected MEDICARE Part B coverage when reaching age 65. As a result, waivers were requested to avoid paying penalties for those in a base closure area. Waivers were granted and initial efforts made to seek legislation to make waivers automatic.

PHARMACY SERVICES

Pharmacy service was a large concern to all beneficiaries, but particularly to those in frail health and the aging. Access to no-cost prescription drugs had been a benefit that had been taken for granted by DoD beneficiaries through the pharmacy at SBHACH. Until July 31, 1993 the PRIMUS clinics in Salinas and Monterey also provided no-cost pharmacy services. Once the pharmacy at SBHACH closed on June 30, 1994, the following services were available:

- **For active duty personnel**--Prescriptions filled at the military clinic at the Presidio of Monterey. Limited service is available for those other beneficiaries who are able to be seen on a space available basis.

- **For family members of active duty personnel, retirees and their family members participating in the TRICARE programs**--Prescriptions are filled at a participating Longs Drug store for a co-payment of $5.00.

- **For those DoD beneficiaries 65 and over who are within the catchment area of Silas B. Hays Hospital (40-mile radius of Ft. Ord)**--Prescriptions may be filled at a participating Longs Drugs store with a co-payment of 20%. This benefit is the result of special Base Closure legislation by Congress.

- **For all DoD beneficiaries**--In May 1994, DoD instituted a new mail-in pharmacy service available to all DoD beneficiaries. The costs are minimal--$4.00 for some beneficiaries, and $8.00 for most beneficiaries. This new benefit provides a cheaper alternative to the 65 and older beneficiaries for routine health maintenance pharmaceuticals. Non-routine prescriptions can be filled by one of the alternatives cited above.

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[15] *Ibid*

CHANGE IN DOD CONTRACTOR

In 1989, the DoD established a new managed care program in California and Hawaii called the CHAMPUS Reform Initiative (CRI). In addition to the standard CHAMPUS program in existence for some time, the CRI program introduced CHAMPUS PRIME and EXTRA to programs available within the two test states. To administer the new program, DoD selected Foundation Health Plan.

Contract Re-competed

The SBHACH closure was complicated when the DoD announced the CHAMPUS Reform Initiative managed care contract was to be re-competed in 1993. This occurred early in the year, with the announcement in late summer that Foundation Health Plan had been succeeded by Aetna Government Health Plan. Transition preparations included a six month turn-over period, culminating February 1, 1994, when Aetna assumed control of the entire program, now renamed TRICARE.

Impacts

The impact of transitioning from one contractor to another was exacerbated by the fact that Silas B. Hays Hospital clinics were closing at exactly the same time. DoD advised that the closure of the hospital "should not be a problem" because a high-quality managed care program had been established for military beneficiaries in California. CRI, in fact, had been declared a model for the nation. The RAND Corporation described, in its evaluation of the program, "high user satisfaction" as one of the positive aspects of the initiative. The reality of the situation, however, was that the transition from one managed care contractor to another occurred at the same time the hospital was closing and produced a situation that was anything but smooth. The local provider network had not been fully developed and the medical community was not accustomed to working outside of a standard fee-for-service model.

Mediation

The Silas B. Hays Blue Ribbon Committee was fully engaged and meeting regularly during this period. It found itself virtually acting as intermediary between the contractors on several occasions. Numerous issues arose for the Monterey area, including a reluctance on the part of a number of local providers to make the transition between contractors. In late 1993, the Blue Ribbon Committee found it necessary to invite senior staff of each contractor organization and the Office of CHAMPUS to the table to discuss network size, makeup and transition timing. It was discovered that local health care providers were hesitant to switch contractors largely because they had heard of a possible protest of the contract award. This concern proved true when, in December 1993, it was announced that indeed, the TRICARE contract was considered flawed by the Government Accounting Office (GAO). DoD determined that the transition should continue, but that the contract would be re-competed again in 1994, with a new contract in place by early 1995--more uncertainty.

Transition

For the DoD beneficiaries who had enrolled in the CRI program, the transition was a difficult period. Many had to once again find a new Primary Care Manger (PCM) and/or specialist. Aetna experienced some delays in establishing their network. Under provisions of the DoD contract, fee schedules were reduced and many physicians opted out of the DoD program. Aetna did succeed in establishing contracts with the three

major civilian hospitals in the local area. In effect, however, "the changeover of CHAMPUS TRICARE contractors was inordinately complicated and disruptive."[16] Finally, the process was to be repeated with a new contract in early 1995. However, as discussed in Chapter 4, re-competition and award of a new contract was postponed in late 1994 as DoD made plans to expand the CHAMPUS TRICARE program nationwide.

Monterey Region Provider Network

At the time when Foundation Health Plan established its CHAMPUS PRIME and EXTRA provider networks, there were several Military medical treatment Facilities (MTFs) operating in the Monterey region. With this relatively wide selection of MTFs, Foundation Health Plan was required to provide only limited resources in the areas of Primary and specialty care. However, with the closing of both PRIMUS clinics in July 1993, and SBHACH in July 1994, the need for basic and special medical care increased dramatically. Foundation Health Plan lost the DoD CHAMPUS managed-care contract to Aetna Government Health Plan in January 1994. With the increased need in medical services, Aetna is now providing approximately three times the medical services that Foundation Health Plan furnished. See Table 4, which represents the last source of data published by Aetna.[17] Appendix E provides more detailed information concerning the services each contractor was, or is providing under the CHAMPUS TRICARE contract.

Table 4 **- Provider Network Comparison**

Benefits/Physician Comparison	Foundation (Nov '93)	Aetna (Jun '94)
	Number of	Physicians
I. Primary Care Physicians	34	135
II. Specialty Care Physicians	91	225
TOTAL:	125	360

CLOSURE OF SILAS B. HAYS HOSPITAL

On July 1, 1994, a formal ceremony was held to mark the closure of SBHACH. The 400,000 square foot facility had seen its last patient.

The California Medical Detachment (CMD) assumed responsibility for DoD health care delivery in the area. A small Coordinated Care Division (CCD) was retained to continue the task of beneficiary disengagement and assignment to new programs. The CMD and CCD opened new offices in the vacant Troop Medical Clinic at Ft. Ord. Aetna moved its local service center to the same facility.

Equipment within the SBHACH building was either redistributed according to the needs of other installations, placed in storage for potential reuse by civilian entities, or disposed of through the Defense Reutilization process at the site on Ft. Ord.

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[16] *Ibid.*, pg. 4

[17] TRICARE PRIME & EXTRA *Provider Directory*, Coastal and Bay Areas, April 1994 (as modified in June 1994).

The DoD plans to retain the hospital for use as an office building to house a Defense Finance and Accounting Center and other DoD organizations currently in rental space in the local area.

LESSONS LEARNED -TRANSITION AND CLOSURE

Topic 3-1: PRIMUS Clinics

Discussion: The two PRIMUS Clinics provided excellent service to all DoD beneficiaries. Their closure on July 31, 1993 greatly accelerated changes for beneficiaries. The opening of an outpatient clinic by the Monterey county hospital in the Salinas area in the same facility with essentially the same staff came some 60 days after. In the interim, most PRIMUS patients in the Salinas area who were eligible for CHAMPUS PRIME and EXTRA or MEDICARE had enrolled with new doctors. Later, most switched back to the County clinic.

Lesson Learned: Most of the change for a group of beneficiaries in the Salinas area could have been avoided by planning for the transition.

Recommendation: Make early attempts to find a replacement program for a PRIMUS Clinic, to ensure a smooth transition.

Topic 3-2: Disengagement of Beneficiaries

Discussion: The MEDDAC at Ft. Ord worked hard to disengage patients and find them new providers. Additionally, information programs, daily briefings, health fairs and networks through retiree organizations encouraged disengagement. Beneficiaries 65 and over were especially concerned and vocal about converting from the DoD programs to MEDICARE. Many required waivers for Part B coverage.

Lesson Learned: In spite of efforts by the MEDDAC, beneficiaries delayed their decisions or, in some cases, found ways to reenter the DoD system after disengagement.

Recommendation: Use every means available to assist with the disengagement of beneficiaries and their assignment to new providers.

Topic 3-3: Change in DoD Contractors

Discussion: The whole process of changing DoD managed-care contractors was difficult. Beneficiaries were confused and concerned. Civilian physicians, hospitals and staffs were skeptical about changing contractors, billing systems and fee schedules. It took considerable effort by organizations such as the Blue Ribbon Committee and MoReHEALTH to detect problem areas and find solutions.

Lesson Learned: The process of changing DoD contractors is difficult in itself. A coordinating organization can assist all parties in the transition. Even so, the change cannot be made transparent to the beneficiaries.

Recommendation: Do not change DoD contractors during the closure of a military hospital.

Topic 3-4: Medical Records

Discussion: Medical records are extremely important to those beneficiaries being disengaged from a closing hospital. The same holds true for x-ray records. For those active duty personnel remaining in the Monterey area at the Defense Language Institute and the Naval Postgraduate School, records were transferred to the Troop Medical Clinic at the Presidio of Monterey. For family members of active duty personnel, retirees and their family members, medical records were to be sent to the Medical Records Depository in St. Louis, Missouri. Therefore, copies of those records to be transferred had to be made available to beneficiaries prior to closure. Rather quickly, the process of sorting and copying records bogged down due to volume. A contractor was hired to assist the hospital staff.

Lesson Learned: The entire process of sorting, copying and providing copies of medical records (and x-rays) is critical to effective closure of a hospital and disengagement of beneficiaries.

Recommendation: Organize, staff and fund the medical records retirement process. Start early and advertise the plan aggressively.

CHAPTER 4

CURRENT STATUS

PURPOSE

This Chapter describes the status of health care delivery services in the Monterey region today based on findings from an ongoing DoD health beneficiary survey project. The data represent beneficiary responses both before and after the closing of the local military treatment facilities. Additionally, the Chapter depicts expansion of health care services to the area's veterans, This is the first partnership of its kind in a base closure area between the Department of Veterans Affairs and DoD. There is also a discussion on the transformation occurring in the health care delivery system available to DoD beneficiaries, and the ultimate need for a "seamless system." The Chapter concludes with some observations about what the immediate future may hold.

MILITARY HEALTH SERVICES SYSTEM (MHSS) SURVEY PROJECT

Background

At the request of the Assistant Secretary of Defense for Health Affairs, ASD(HA), the Defense Health Resources Study Center (DHRSC) has conducted several nationwide surveys of Military Health Services System (MHSS) beneficiaries over the past 18 months. This project represents a major step in advancing "Managed-Care" and "Capitated-Budgeting" concepts in the DoD environment. The results of the surveys form the justification for DoD's $15B health budget allocations for each fiscal year.

The MHSS beneficiary population (excluding active duty military personnel) is estimated at approximately 6.5 million eligible individuals. Over 1,250,000 beneficiaries have been solicited for responses between February and November 1994. Those beneficiaries targeted for the national surveys were selected from the Defense Eligibility and Enrollment Reporting System (DEERS) database. The demographic categories used to stratify the samples taken included:

- Retirees under 65, and their dependents
- Retirees 65 and over, and their dependents
- Dependents of active duty beneficiaries

These nationwide surveys are being used to gather information on how military beneficiaries use health care services.[18] Two recent phases of this surveying project ended in February 1994 and November 1994 and generally reflect responses before and after the closure of the Silas B. Hays Hospital on Ft. Ord. Results from these two surveys have been segregated by zip-code to create a Monterey catchment area (defined as a forty mile radius around Monterey). The defined catchment area is given in Appendix F. The primary Military Treatment Facility (MTF), Silas B. Hayes Army Community Hospital (SBHACH), closed during the time-span between the two surveys; therefore the surveys have been designated "pre-closing survey"

[18] For more information on the methodology and results of the OASD(HA)/DHRSC MHSS beneficiary surveys, contact the Office of the Assistant Secretary of Defense for Health Affairs, 5 Skyline Place, 5111 Leesburg Pike, Falls Church, VA 22041-3206, Phone 703-756-7888

(data reflecting information about the period July 1993-February 1994),[19] and "post-closing survey" (date reflecting information about the period May 1994-November 1994).[20]

MONTEREY REGION SURVEY ANALYSIS

The following analysis looks at the data responses in the "pre" and "post" closing surveys for the Monterey catchment area. The survey instruments used for each of these surveys are provided in Appendix G.

Pre-Closing versus Post-Closing Inquiry and Response Rates

Table 5 displays the inquiry and response numbers, and the response rates for the two Monterey catchment survey populations.

Table 5 **- Pre and Post Closing Sample Groups**

SAMPLE GROUPS	INQUIRY	RESPONSES	% RESPONSE
PRE-CLOSING[1]			
Under 65	XXX	655	XXX
65 and Over	XXX	695	XXX
Total	XXX	1350	XXX
POST-CLOSING[2]			
Under 65	8049	3473	43.1%
65 and Over	4953	3025	61.1%
Total	13002	6498	50.0%

Notes: (1) Inquiry and response rate information was not calculated because the pre-closing MHSS survey was not adjusted at the zip-code level for individuals who moved during the survey.
(2) Post-closing response rates can also be developed for each zip-code.

Table 6 reveals the response percentage and number differences between the pre-closing and post-closing surveys. The table breaks-out each question by age category and notes when the percentage changes are statistically significant. There were some differences between the actual survey instruments for the two surveys as noted below:

[19] MHSS User Survey-Phase II (Data collection dates Jan-Mar 1994).

[20] *Ibid*, Phase IV (Data collection dates Oct-Nov 1994).

- The pre-closing survey used a "sample group" from the total Monterey catchment area. The post-closing survey included the entire population as defined in the DEERS database. This resulted in a significantly larger number of responses in the post-survey as compared to the pre-survey.

- The post-closing survey was only sent to beneficiaries in the first two categories (i.e., dependents of active duty beneficiaries were not queried). Therefore, the analysis was limited to only the first two demographic categories.[21]

- The post-closing survey changed slightly:

  - The term "Veterans hospital" was used in place of "other" in questions 3c, 4c, 5c, & 7c; and,
  - An extra question was asked on where medical care would be obtained in the next six months (see Table 7).

Inpatient Use of Hospital Facilities

As one would expect, use of the inpatient MTF services decreased after SBHACH closed while inpatient use (using CHAMPUS) increased. An unexpected result was the statistically significant decrease in inpatient hospital use by those 65 and over. Access was reduced for these beneficiaries.

Outpatient Use of Health Care Facilities

Figure 6 shows the dramatic drop in use of outpatient MTF usage after the closure of SBHACH. An increase in Outpatient CHAMPUS usage is also reported in Figure 7. Interestingly enough, there is no statistically significant shift in use of civilian facilities with private payment for either age group.

Pharmacy Usage

Figure 8 and 9 displays the significant shift from military to civilian pharmacies (using CHAMPUS) for the refilling of prescriptions. Even those in the age group 65 and over reported an increase in pharmacy usage with CHAMPUS payments. A special BRAC waiver has been allowed for the 65 and over category to use CHAMPUS for pharmacy refills due to the closing of the army base at Ft. Ord. It is interesting to note that a significant change did not occur in civilian pharmacy refill rates using private payments.

Satisfaction with Health Care

Table 6 does not reveal any statistically significant shift in overall satisfaction levels of health care between the pre-closing and post-closing surveys. This may be the most important finding when analyzing the survey results. However, it should be noted that the post-closing survey was conducted 4 months after SBHACH closed, and the survey question asks how satisfied the beneficiary was with "health care received during the last 6 months." An unequivocal statement that satisfaction levels have not changed since the closing of SBHACH cannot be made without more research. Data from future phases of the MHSS health beneficiary survey, scheduled to commence in April and September 1995, will further refine the comparison.

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[21] It should be noted that the post-closing survey included a 100% sampling of the Monterey region for the two categories indicated, and was funded by DHRSC.

Table 6 - **Pre-Closing versus Post-Closing Survey Data**

	Pre-Closing		Post-Closing	
Category Questions/Items	Retired/Dependent Under 65 Percent/(#)	Retired/Dependent 65 and Over Percent/(#)	Retired/Dependent Under 65 Percent/(#)	Retired/Dependent 65 and Over (Percent/(#)
Number of Respondents	48.5% (655)	51.5% (695)	53.4% (3,473)	46.6% (3,025)
Private Insurance				
YES	46.3% (302)	93.0% (639)	48.7% (1,687)	94.4% (2,837)
NO	53.7% (350)	7.0% (48)	51.3% (1,776)	5.6% (167)
Inpatient MTF				
Not Used	97.4% (638)	95.5% (664)	99.0% (3,438)*	98.3% (2,975)*
Used	2.6% (17)	4.5% (31)	1.0% (35)*	1.7% (50)*
Inpatient CHAMPUS				
Not Used	98.2% (643)	98.7% (686)	96.7% (3,357)*	98.1% (2,967)
Used	1.8% (12)	1.3% (9)	3.3% (116)*	1.9% (58)
Inpatient Private				
Not Used	97.1% (636)	87.9% (611)	97.3% (3,378)	90.4% (2,735)*
Used	2.9% (19)	12.1% (84)	2.7% (95)	9.6% (290)*
Outpatient MTF				
Not Used	65.2% (427)	62.4% (434)	88.9% (3,088)*	87.4% (2,643)*
Used	34.8% (228)	37.6% (261)	11.1% (385)*	12.6% (382)*
Outpatient CHAMPUS				
Not Used	62.7% (411)	92.4% (642)	53.8% (1,868)*	88.8% (2,686)*
Used	37.3% (244)	7.6% (53)	46.2% (1,605)*	11.2% (339)*
Outpatient Private				
Not Used	63.5% (416)	26.6% (185)	64.2% (2,230)	26.5% (803)
Used	36.5% (239)	73.4% (510)	35.8% (1,243)	73.5% (2,222)
Pharmacy MTF				
Not Used	57.7% (378)	40.1% (279)	88.1% (3,059)*	79.9% (2,416)*
Used	42.3% (277)	59.9% (416)	11.9% (414)*	20.1% (609)*
Pharmacy CHAMPUS				
Not Used	75.3% (493)	94.5% (657)	59.2% (2,057)*	77.6% (2,348)*
Used	24.7% (162)	5.5% (38)	40.8% (1,416)*	22.4% (677)*
Pharmacy Private				
Not Used	70.8% (464)	48.3% (336)	71.4% (2,478)	45.8% (1,386)
Used	29.2 (191)	51.7% (359)	28.6% (995)	54.2% (1,639)

* Statistically significant change from Pre-Closing results (Confidence Level of 95%)

Table 6 - **Pre-Closing versus Post-Closing Survey Data (Continued)**

	Pre-Closing		Post-Closing	
Category Questions/Items	Retired/Dependent Under 65	Retired/Dependent 65 and Over	Retired/Dependent Under 65	Retired/Dependent 65 and Over
	Percent/(#)	Percent/(#)	Percent/(#)	Percent/(#)
Satisfaction with MTF				
Very Satisfied	76.0% (200)	76.9% (257)	74.0% (250)	73.0% (273)
Neither	5.7% (15)	5.4% (18)	8.3% (28)	4.8% (18)
Very Dissatisfied	18.3% (48)	17.7% (59)	17.8% (60)	22.2% (83)
Satisfaction with CHAMPUS				
Very Satisfied	82.4% (202)	78.6% (22)	78.4% (1,235)	83.5% (238)
Neither	7.3% (18)	10.7% (3)	7.7% (122)	6.7% (19)
Very Dissatisfied	10.2% (25)	10.7% (3)	13.9% (219)	9.8% (28)
Satisfaction with Private Care				
Very Satisfied	90.7% (205)	89.5% (437)	88.8% (1,065)	88.3% (1,930)
Neither	4.9% (11)	5.7% (28)	5.6% (67)	5.8% (127)
Very Dissatisfied	4.4% (10)	4.7% (23)	5.6% (67)	5.9% (129)
Self-describe personal health				
Excellent/Very good	47.7% (310)	31.4% (217)	49.1% (1,676)	29.3% (862)
Good	33.8% (220)	36.1% (249)	34.4% (1,174)	38.9% (1,145)
Fair/Poor	18.5% (120)	32.5% (224)	16.6% (566)	31.9% (938)

Table 7 - **Additional Post-Closing Question**

	Pre-Closing		Post-Closing	
Category Questions/Items	Retired/Dependent Under 65	Retired/Dependent 65 and Over	Retired/Dependent Under 65	Retired/Dependent 65 and Over
	Percent/(#)	Percent/(#)	Percent/(#)	Percent/(#)
Future health care choice (Next 6 mths):				
Military health care			6.2% (212)	7.8% (228)
Civilian Health - Paid by CHAMPUS			58.5% (1,994)	8.5% (247)
Civilian-Private/VA			35.2% (1,200)	83.7% (2,439)

Question 6: "*If you needed medical care during the next 6 months, where would you most likely go to obtain it?*"

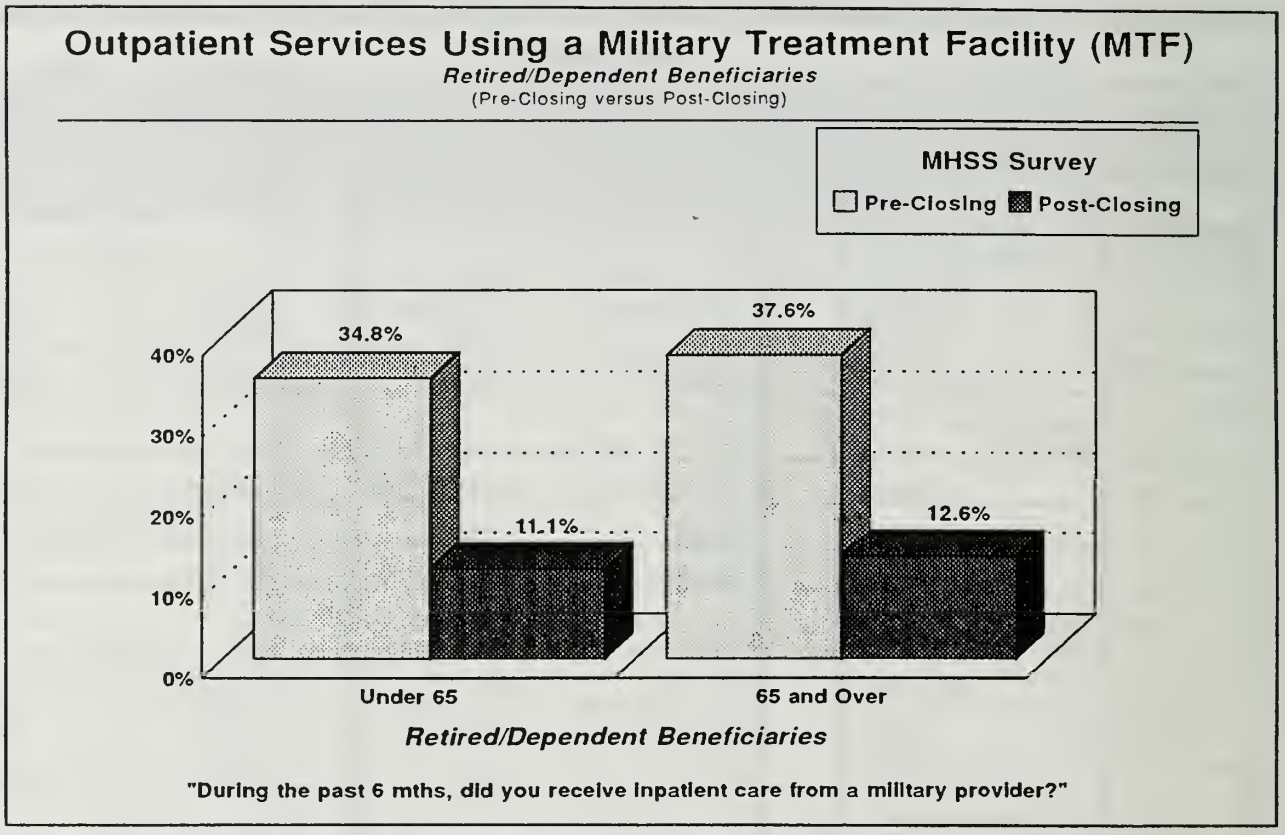

Figure 6 - **Outpatient Services Using a Military Treatment Facility (MTF)**

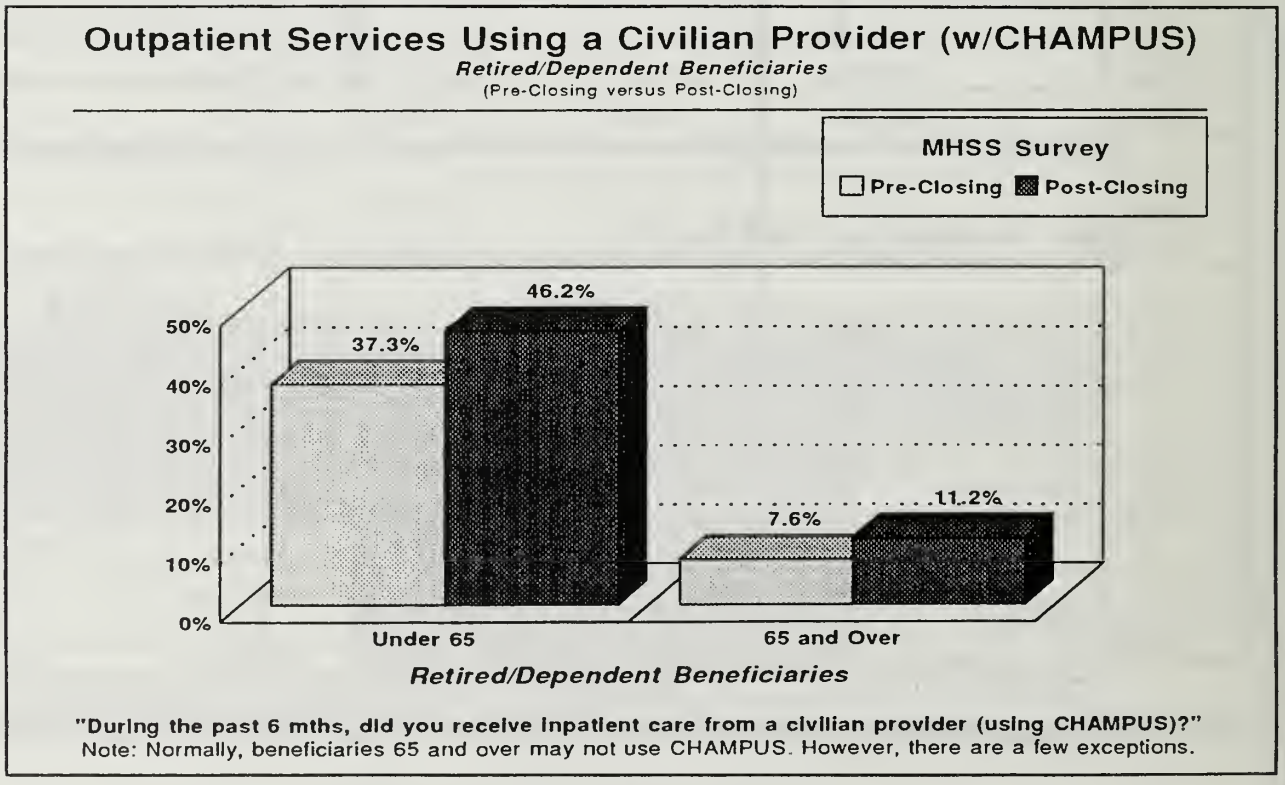

Figure 7 - **Outpatient Services Using a Civilian Provider (w/CHAMPUS)**

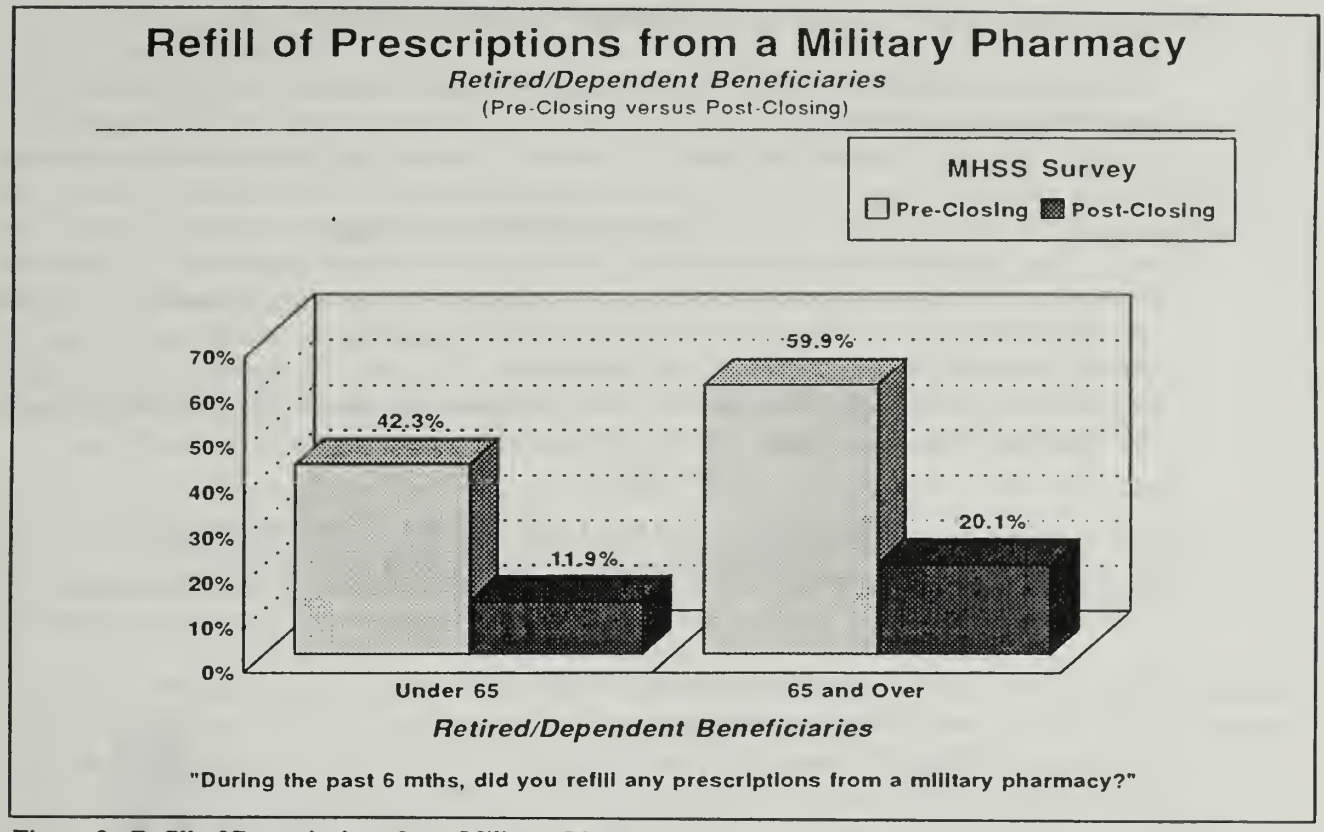

Figure 8 - **Refill of Prescriptions from Military Pharmacy**

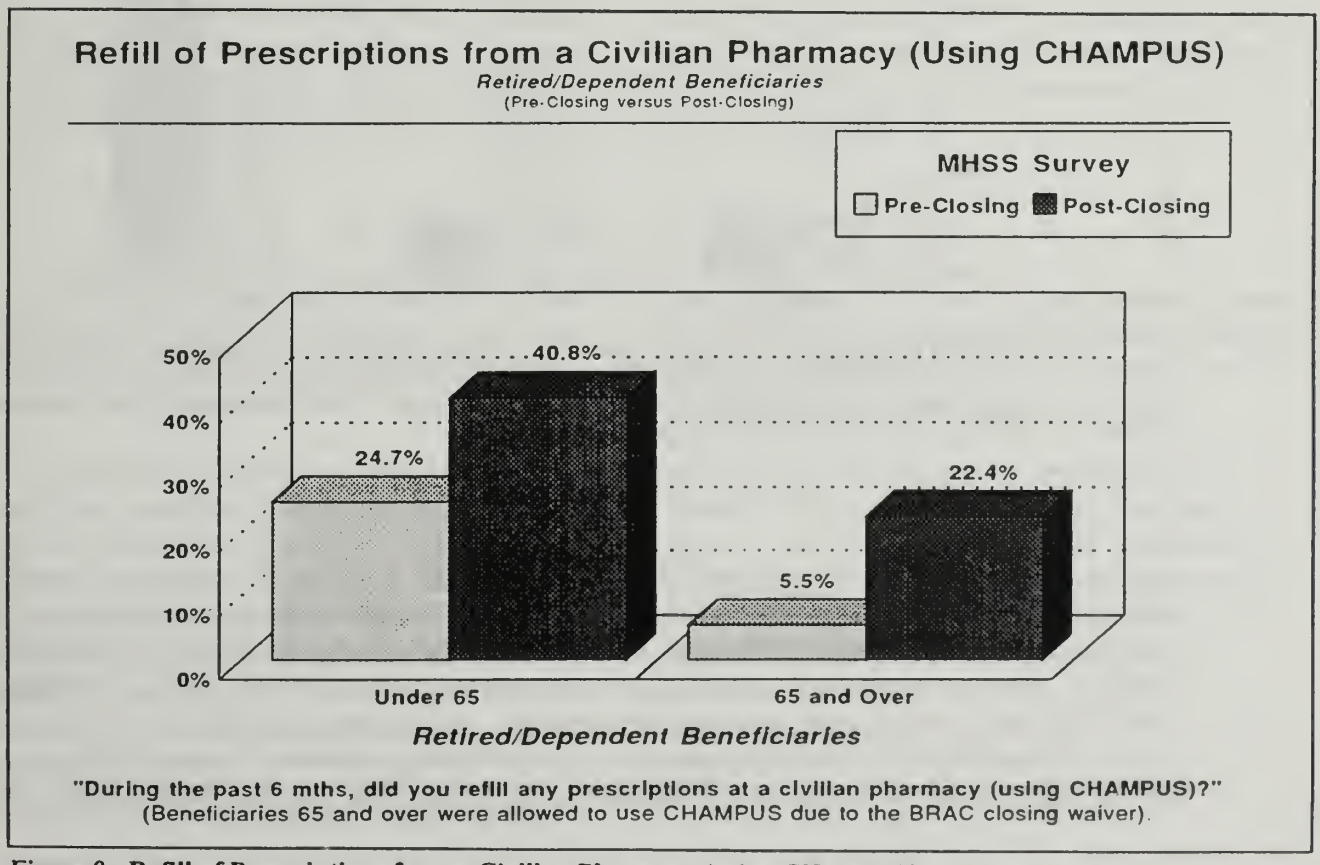

Figure 9 - **Refill of Prescriptions from a Civilian Pharmacy (using CHAMPUS)**

Self-Described Personal Health

There was not a significant shift between the pre-closure and post-closure surveys of beneficiaries overall self-reported personal health.

Future Health Care Usage

Results from the additional question in the post-closing survey is shown in Figure 10. The question asks, *"If you needed medical care during the next 6 months, where would you most likely go to obtain it?"* The question does not specify if inpatient or outpatient care is the issue. The majority of those under 65 reveal they expect to obtain health care from a civilian provider using CHAMPUS. Those 65 and over show an overwhelming expectation to use civilian providers (with private payments) or VA clinics.

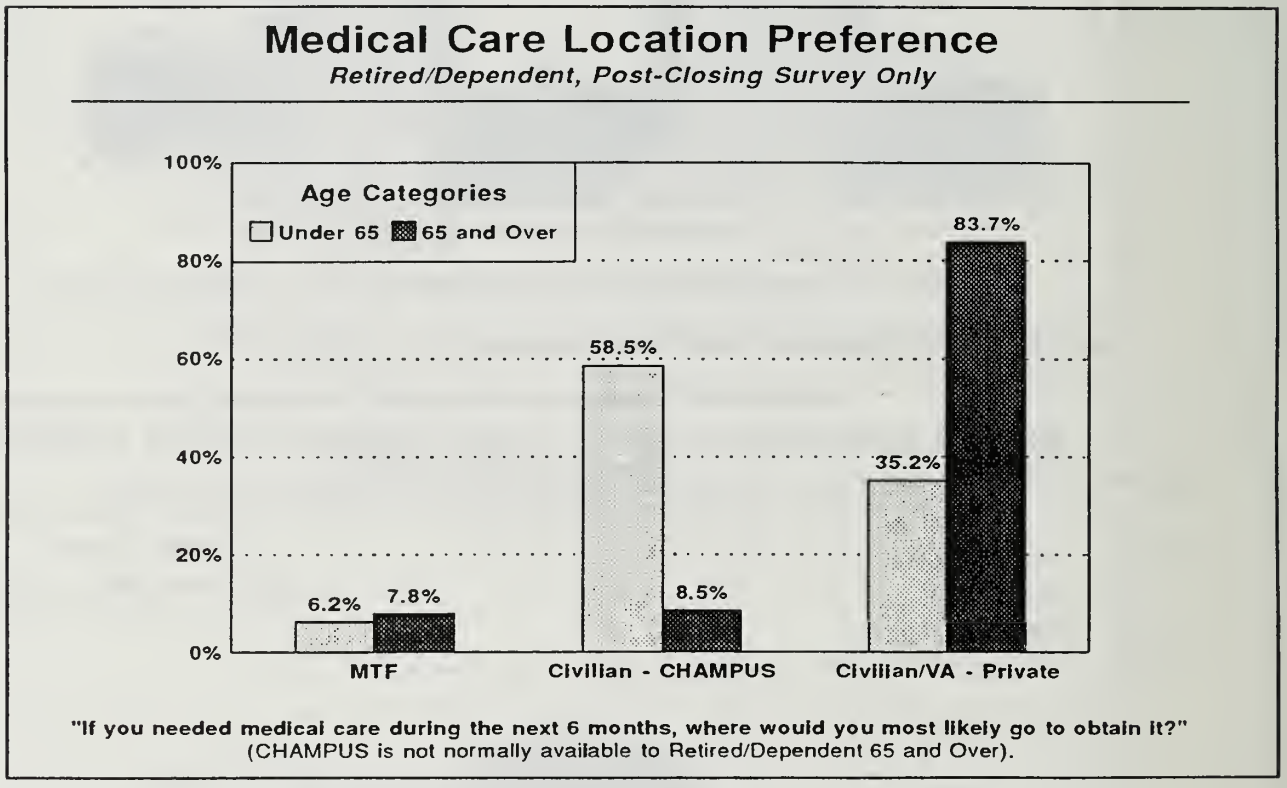

Figure 10 - **Medical Care Location Preference**

Conclusions

It is too early to draw any firm conclusions from this analysis. However, the data point to an expected decrease in the usage of MTF's and an increase in CHAMPUS care. It appears that civilian care using private payments (and possibly VA usage) does not statistically change for inpatient, outpatient, or pharmacy service. Furthermore, satisfaction levels have not statistically changed since the closing of SBHACH and personal health status of individuals also remains relatively stable. As future nationwide surveys are conducted, it will be important to continue tracking beneficiary use and satisfaction levels in order to monitor the adequacy of local health care delivery systems. The next survey sample taken by the

MHSS survey project will include information about a six month period which is entirely beyond the closing date of SBHACH.[22]

The timing of the pre- and post-MHSS surveys provided a valuable tool to analyze military beneficiaries use of medical health care and their perceived satisfaction, particularly with the closing of the primary MTF in the Monterey catchment area. Since the nationwide surveys are distributed by zip-code, future military bases/health care facilities affected by BRAC closings may be able to use a similar technique of segregating the data by defined catchment areas. Additionally, political representative's districts can be extracted to monitor military constituents' use of, and attitudes about local health care services.

DEPARTMENT OF VETERANS AFFAIRS CLINIC

Background

The Department of Veterans Affairs (VA) has a well established medical care system across the nation. That system is available to eligible veterans according to their disabilities, income levels and other determinations. A brief description of eligibility and rate information is provided at Appendix H.[23]

In central California, there is a large VA Medical Center (VAMC) located in Palo Alto, some 80 road miles from the Ft. Ord area. With few exceptions, each county government in the state has an Office of Veterans Services which provides an interface between the veteran and the entire VA system, including health care. In Monterey County, the Veterans Services office assists veterans in scheduling appointments at the VA Medical Center and provides shuttle bus service 4 days a week for those unable to make the trip alone.

There are an estimated 70,000 veterans in Monterey County. Of that number, 17,000 are retirees. The latter were eligible as DoD beneficiaries for health care through SBHACH or one of the DoD programs such as CHAMPUS or TRICARE. By definition, all retirees are veterans. However, most veterans are not retirees since they did not serve the minimum of 20 years to qualify for retirement.

Concept and Planning for VA Clinic at Ft. Ord.

As plans were being formulated to close Ft. Ord and the base hospital, the Director of the Monterey County Veterans Services Office approached the leadership of the VAMC in Palo Alto and asked that they consider opening an outpatient clinic on Ft. Ord property. The Director and his staff responded positively to the concept and briefed the Blue Ribbon Committee in late 1993 on their proposed plans.

Two possible locations were identified: the outpatient section on the first floor of the SBHACH building; and, the Consolidated Troop Medical Clinic (CTMC). In early 1994, several meetings were held to determine the suitability and availability of those potential sites. Both sites were within the boundaries of the property to be retained by the military. The SBHACH was to be converted to a Defense Finance and Accounting Center, but would have space to accommodate a VA clinic. The CTMC was eventually to be declared excess, and plans by the California State University system called for its use as a potential infirmary.

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[22] Semi-annual nationwide sampling of all military treatment facility (MTF) 40-mile radius catchment areas, and 57 state and regional out-of-catchment areas are currently planned by OASD(HA)/DHRSC.

[23] VA Clinic of Monterey advertisement brochure, and Department of Veterans Affairs, Office of Public Affairs Pamphlet No. 80-94-1, *Federal Benefits for Veterans and Dependents*, 1994.

In June 1994, agreements were concluded among the VA, the new California State University campus, Monterey County, and the Army which would allow the VA to move to the CTMC. MoReHEALTH helped facilitate the agreements among the parties, and the Army agreed to prepare and staff a permit for the VA to occupy the building.

Temporary VA Clinic

While plans were being finalized for the use of the CTMC, it was apparent that the permit process would take several months. As a result, the VAMC in Palo Alto concluded that it would open a temporary outpatient clinic in rental space in Marina, California, which is adjacent to Ft. Ord property. The doors of the clinic opened on August 15, 1994 and the response by area veterans was most enthusiastic. Additional doctors and staff were soon required to meet increased demand. Specialists in dermatology, cardiology, neurology and mental health were made available on a part time basis each week. Records for late August and September of 1994 are not available, but the growth in patients since then, as shown in Figure 11 has been dramatic.

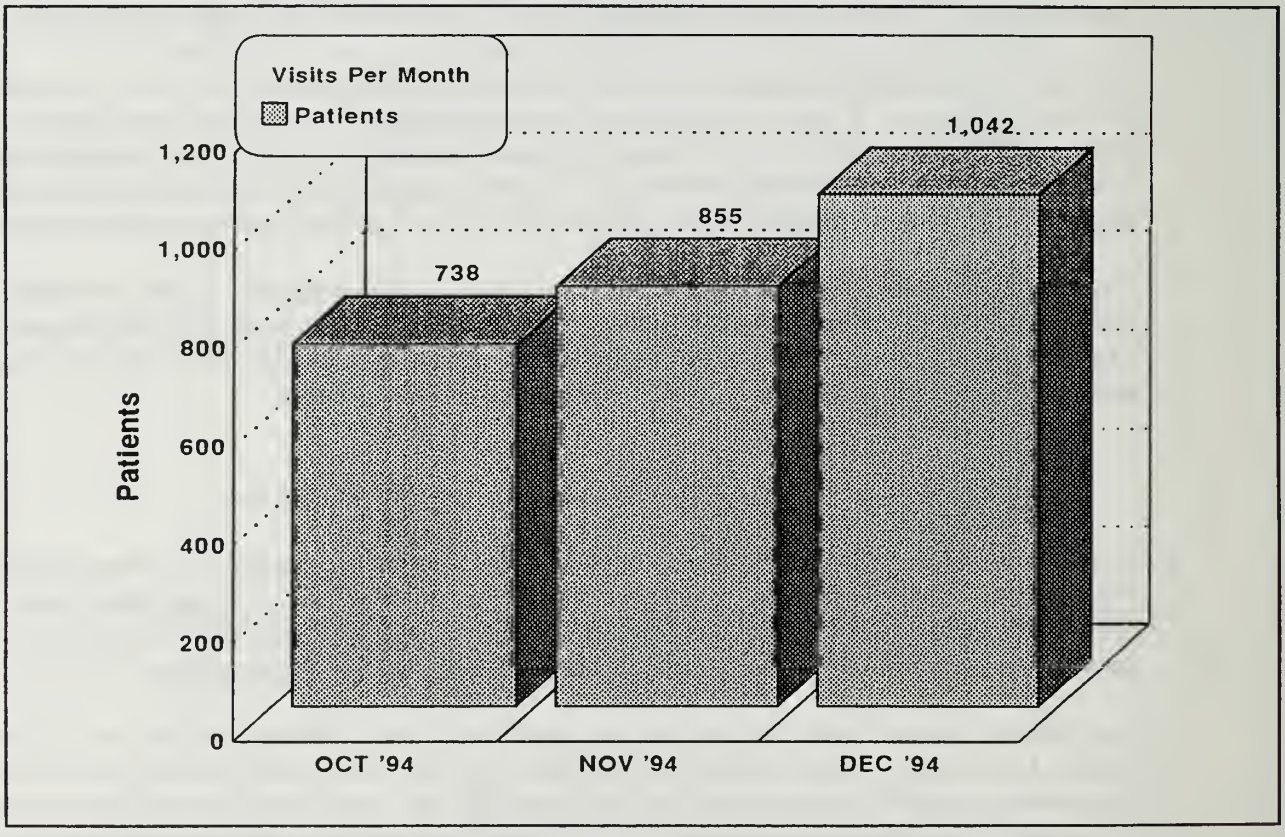

Figure 11 - **Visits per Month to Temporary VA Clinic**

Due to space limitations, the waiting period for appointments grew to 6-8 weeks. However, patient satisfaction remained high (99%) based on patient surveys. Walk-in patients were accepted, but they could expect a long wait. By December 1994, prescriptions were being filled at the rate of 4,000 per month at the clinic. Many retirees who had not previously used the VA medical system switched from care through the DoD or MEDICARE systems to the services offered by the VA.

Permanent VA Clinic

The Army issued a permit to the VA in November 1994 for the use of the former Consolidated Troop Medical Clinic (CTMC) on Ft. Ord property. Next, preparations were made to make modifications to the building to meet VA needs. As of the date of this report, it is anticipated that the new clinic will open for outpatient treatment on March 10, 1995. Additional services and medical specialities will be offered to eligible veterans based on demand. Reaction to the VA clinic by area veterans, to include retirees, has been extremely positive.

THE TRANSFORMATION OF THE MILITARY HEALTH CARE SYSTEM

Background

For over 20 years, the CHAMPUS program provided a health care delivery system to eligible beneficiaries under 65 who could not be treated in a military treatment facility. In 1989, the CHAMPUS Reform Initiative (CRI) was instituted in California and Hawaii. Foundation Health Plan (FHP) was awarded the contract for the new program. It provided low cost medical care for those who enrolled in the program.

In 1993, the DoD re-competed the CRI contract and chose Aetna Government Health Plan as the new contractor as described in Chapter 3. Due to protests and a GAO review, Aetna was allowed to assume the contract on February 1, 1994 from FHP, but the contract was to be re-competed, with selection to be made in late 1994 for another contract in 1995. The process was again delayed so that a new contractor will be selected on March 31, 1995. There are four bidders in contention: Aetna, FHP, Blue Cross/Blue Shield of California, and QualMed. Once the new contractor is selected there will be a six month transition period until September 30, 1995 (unless Aetna is again awarded the contract).

It is unknown what changes, if any, will be made in the CHAMPUS Maximum Allowable Rate which is the fee structure paid to health care providers. In the case of the transition in contracts from FHP to Aetna in February 1994, the fee structure was reduced significantly.

The Emerging CHAMPUS TRICARE System

DoD has decided to make substantive changes to its health care system to reduce costs and to provide better service to eligible beneficiaries. The new system will be applied nationwide between March 1995 and 1997. As a result, those in the Ft. Ord area will once again see changes in their health care delivery system to include changes in fees for service. The new TRICARE programs were published in the Federal Register on February 8, 1995 and comments on the proposed changes will be accepted through April 10, 1995.[24] For the DoD eligible beneficiaries in the Ft. Ord area, some of the changes to the current CHAMPUS TRICARE PRIME program are shown in Table 8.

Again , those retirees and family members age 65 and over will not be eligible for the CHAMPUS TRICARE programs. They must continue to convert to MEDICARE or some other private insurance program. On the bright side, the new DoD program makes provisions for VA hospitals to become part of the TRICARE provider network of hospitals and doctors. This potentially will allow the new VA clinic at Ft. Ord to become a participant in the current network and provide another choice of service for those beneficiaries under age 65.

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[24] *Federal Register*, Vol. 60, No. 26, Wednesday, February 8, 1995, pgs. 7489-7506.

Table 8 - **CHAMPUS TRICARE PRIME Comparison**

	Active Duty Family Members					
	E-4 & Below		E-5 & Above		*Retirees & Family Members*	
Enrollment Fee	$0	$0	$0	$0	$0	$230/Indiv. $460/Family
Outpatient Visit	$5	$6	$5	$12	$5	$12
Prescriptions	$4	$5	$4	$5	$5	$9
Inpatient Per Diem	$0	$11/day	$0	$11/day	$75/day up to $750	$11/day

☐ Current TRICARE PRIME ☐ Proposed TRICARE PRIME

LESSONS LEARNED - CURRENT STATUS

Topic 4-1: Timing of Surveys

Discussion: Understanding how and to what extent military beneficiaries are using health care services is critical for anticipating the future needs of the community. This is especially true when major changes are occurring such as base closures and changes in primary insurance providers. Ideally, a major health survey of military beneficiaries should be conducted before a major transformation is announced. Data can be turned into valuable local information by creating a local "catchment area" for a base closure region and cutting the data with the appropriate postal zip-codes. Future surveys are essential to sense when usage and satisfaction levels are shifting.

Lesson Learned: By using survey data which already existed (i.e., the MHSS survey), the Monterey community established a baseline of health care usage data for its military beneficiaries. After establishing the baseline, additional surveys conducted following the major transformation were evaluated to determine if adjustments were required.

Recommendation: Other communities which encounter major changes in military health care should contact the Office of the Assistant Secretary of Defense (Health Affairs), OASD(HA) to gather the baseline usage data so that similar medical care analysis can be completed. This capacity for ongoing longitudinal assessment of health care status and access will become increasingly important for these communities.

Topic 4-2: Survey Design and Questions

Discussion: The terminology used in the military health care arena can be confusing. The MHSS survey questions may need further refinement, especially when trying to determine "satisfaction" levels of the beneficiary population.

Lesson Learned: "Satisfaction" results gleaned from the MHSS survey should only be used as broad indicators. More thorough questions which clearly define "health care provider," "facility," and "primary insurance provider," should be asked in future surveys.

Recommendation: The survey should be expanded to ask beneficiaries how satisfied they are with:

- The health care provider (doctor/nurse)
- The health care facility (hospital/clinic)
- The CHAMPUS TRICARE managed-care contractor (e.g., Foundation Health Plan or Aetna Government Health Plan)

Topic 4-3: Potential Role for the VA in a Base Closure Area

Discussion: The closure of Ft. Ord and its major hospital caused significant changes in the health care delivery system for military retirees in the area. The leadership of the VA hospital in Palo Alto recognized an opportunity to establish an outpatient clinic on the base to provide expanded services to eligible veterans in the area, reduce travel time and costs, and assist in mitigating the effects of the closure of the military hospital.

Lesson Learned: The VA can play a significant role in the health care delivery system in those areas where a military hospital is closed and beneficiaries remain in the area.

Recommendation: Early planning efforts concerning the closure of a military hospital should include the VA to determine its potential role in expanding VA health care services to DoD beneficiaries. Cooperative arrangements between the DoD and VA can include the VA as a provider for the TRICARE program.

Topic 4-4: Planning Lead Times to Establish a VA Clinic

Discussion: It required 18 months of planning and execution to establish the VA clinic at Ft. Ord. Although a temporary clinic was established some 2 months after the closure of SBHACH, an additional 6 months were required to prepare and staff a permit, work out the details of arrangements between several parties, modify the clinic physical space, and begin operations.

Lesson Learned: Moving from concept to reality takes time.

Recommendation: The organization responsible for base closure and health care planning must begin early discussions with the VA and DoD to realize optimum timing for the opening of a VA clinic. The health care planning should be an ongoing process

Topic 4-5: Resources and Coordination Required to Convert Military Structures

Discussion: Once military structures are vacated, they begin to deteriorate. Reuse planning must account for the costs to rehabilitate the structures and also to convert them to new uses. The Department of Veterans Affairs will spend about $100,000 to refurbish and equip the former Troop Medical Clinic. Additionally, short and long term infrastructure support arrangements must be coordinated. What appear to be non-issues can become show-stoppers (e.g., telephone and utilities services). In another example, plans to convert the Silas B. Hays Hospital to a Defense Finance and Accounting Service (DFAS) Center may require as much as $19M.

Lesson Learned: Reuse plans can easily become delayed.

Recommendation: Reuse planning organizations must be prepared to commit resources to converting buildings, and work out the details of infrastructure support.

Topic 4-6: Application of CHAMPUS Allowable Rates

Discussion: Changes in CRI contractors in February 1994 were accompanied by an estimated 15% reduction in the CHAMPUS Allowable Rates. As a result, there was some reluctance on the part of network providers to enter the new network being established by Aetna in the Monterey and Ft. Ord area, which is semi-rural. In large metropolitan areas, there is more competition among providers and Aetna had much less difficulties, if any, in establishing a provider network. One year after the change in the Monterey area, there are still no Dermatologists in the Aetna network and there is still difficulty in contracting with mental health and ENT specialists. Rates for some specialities are pegged to MEDICARE rates and often the managed-care contractor cannot locate providers who will accept a discount from that rate.

Lesson Learned: There should be flexibility in the allowable rate structure for marginally competitive areas in order to fill the needs of a good provider network. The Los Angeles basin is not the same as northern Montana in developing provider networks.

Recommendation: That DoD plan for flexibility in the application of the allowable rate structure as it expands the CHAMPUS TRICARE system nationwide.

Topic 4-7: Creating a "Seamless" System for DoD Health Care Beneficiaries

Discussion: Closure of a military installation and its hospital creates significant changes and problems for DoD health care beneficiaries. For all those accustomed to treatment in a military facility, disengagement and reassignment to other health care delivery systems is a traumatic experience. For non-active duty beneficiaries, costs for care and pharmaceuticals increase. Most seriously affected are retirees and family members age 65 and over who must enroll in MEDICARE or another private program at increased costs. They feel abandoned by their DoD "family" and resent being "dropped from the rolls" of the military which they honorably served. The Secretary of Defense pledged in 1994 his support of the DoD's plan to allow retirees over 65 years of age to join the CHAMPUS TRICARE program with MEDICARE paying to cover the costs.[25]

The new DoD CHAMPUS TRICARE system will now allow treatment of beneficiaries (including family members) under age 65 in the VA medical system. This is a most positive step in the right direction and has been highly praised by those in the Ft. Ord closure area.

Still lacking are the mechanisms through legislation that would allow DoD beneficiaries age 65 and over to be included in the CHAMPUS TRICARE system.

The Secretary of Defense has referred to health care of our military population as part of a "sacred trust ... the trust our forces and retirees deserve to have in their leadership ... [to do] the right thing."[26]

Lesson Learned: Many DoD beneficiaries, age 65 and over, regard being dropped from the DoD CHAMPUS TRICARE system as a violation of a sacred trust.

Recommendation: Enact legislation whereby the DoD managed care system can include those beneficiaries age 65 and over. Allow DoD to be reimbursed by MEDICARE. Create a "seamless" system for all DoD beneficiaries.

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[25] Perry, William J., Secretary of Defense, speech at the National Naval Medical Center, Bethesda, MD, July 6, 1994.

[26] *Ibid.*

CHAPTER 5

OBSERVATIONS FOR THE FUTURE

PURPOSE

This Chapter describes a model of how communities may react to the announcement and implementation of a base or facility closure, and one community's move toward reuse and economic growth. Additionally, the Chapter depicts the evolution of the MoReHEALTH and FORA relationship into a reuse partnership. A schedule of the conferences to be conducted in the near future, to educate other base closure communities is provided. Finally, there are suggestions regarding how to continue to learn from the closing of Ft. Ord and to apply that experience throughout the continuing changes in the military health system.

INTRODUCTION

The interrelationship of health care issues is complex, especially when coupled with major upheavals such as military base closures and managed-care program changes. Health care coverage of military beneficiaries is also undergoing tremendous change. At a time when the nation's civilian health care system is changing to managed care and capitation, the military health care system offers much as a model. For decades, career military and their families were provided health care, originally directly through the medical services on bases and posts throughout the world, and later through payment mechanisms like CHAMPUS TRICARE, and contracts with private practitioners. During active duty, as part of the benefits they would receive, career military personnel were told they--and their families--would be taken care of for life. While the reality of this promise is debated today, the facts remain that thousands of retirees and their dependents moved to specific areas of the country in order to be close enough to receive medical services from Military Treatment Facilities (MTFs) on active duty bases and posts.

COMMUNITY REACTION

Community Response Model

These changes occurred at a time when the community's capacity to deal with crisis was at its lowest. One integrated model by Kilpatrick (1988), based on research by Elizabeth Kubler-Ross is presented in Figure 12.[27] It describes the stages that individuals, organizations--and communities--may experience and the responses exhibited when dealing with crises. If one reviews what the Monterey area community experienced, much of their actions reflected the responses characteristic of each of the stages which follow:

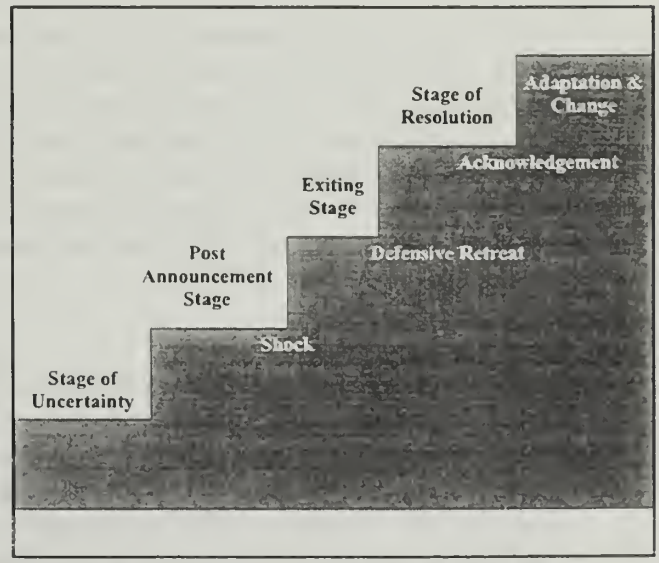

Figure 12 - **Stages of Crisis During a Cutback**

[27] Kilpatrick, A.O. (1988). Humanizing the downsizing process in hospitals and other health care facilities. *Journal of Health and Human Resources Administration*, 10(4), pgs. 335-350.

- **Stage of Uncertainty**--This stage began before the announcements were made regarding base and military treatment facility closures. The community is filled with uncertainty, rumors and frustration. Information is frequently inaccurate and limited. The Monterey area community was in danger of losing one of its three largest economic partners--the United States Army, represented by the 31,000 residents of Ft. Ord. The municipalities and the county--in addition to losing many residents and local revenues--were going to be required to take on the major challenge of planning the redevelopment of a large military base. The Monterey area community spent many months trying to delay the inevitable closing of Ft. Ord. The Ft. Ord Community Task Force, formed by then-Congressman Leon Panetta, was established to direct an organized effort to stop the base and hospital closure, while also measuring the possible economic consequences of closure.

- **Post-Announcement Stage**--Even when a closing is not a surprise, the actual announcement creates anxiety. There can frequently be resentment and consternation among residents, particularly military beneficiaries. The shock experienced by an area's leadership can frequently result in immobility and negative inertia among community leaders, at a time when much action should be taken. In the case of Ft. Ord, and SBHACH, the impact was minimized by proactive planning by these leaders. The work of the Ft. Ord Community Task Force, and its Health, Community and Public Services Advisory Group, established a strategy to deal with the base and hospital closure.

- **Exiting Stage**--At the point at which the closure is being implemented, reuse and redevelopment plans must be made. However, these plans may be delayed if organizations and communities experience *defensive retreat*. In this case, municipalities and communities may retrench and fight each other, the military, or "the government." "Scape-goating" is a very real possibility. During this stage, the Ft. Ord Reuse Group (FORG) was established to turn the reuse strategy into a base reuse plan. FORG represented the community's move from the *defensive retreat* response to *acknowledgment*. As noted in Chapter 1, FORG operated on consensus. Planning was delayed at times due to a lack of consensus on key issues. As health care delivery systems started to be phase out, the Blue Ribbon Committee on health care was established to address problem areas, and to advise FORG on its reuse planning efforts.

- **Stage of Resolution**--Once there is acknowledgment of the situation, there can be an acceptance that there is no longer a crisis, and there can be new roles and opportunities in the community, and *adaptation and change* may take place. Due to problems inherent in FORG and its consensus operation, the Ft. Ord Reuse Authority (FORA) was established by state legislation to oversee all reuse planning and execution. As for health care, the Blue Ribbon Committee evolved into a permanent organization--MoReHEALTH-- to identify community health care needs, identify and work on solutions to problem areas and to advise and assist FORA in reuse and redevelopment opportunities of Ft. Ord.

Variables Important to Transition Survival

Resources--One driving force was the quality of volunteers. Military retirees and other residents, respected by the larger community, and who knew the community, military system and Ft. Ord, gave of their time to assist in creating an organization to assess the impact of closing the MTFs in the area. They directed a regional health study with funding for the study obtained through Monterey County from the Office of Economic Adjustment (OEA). The Naval Postgraduate School Foundation, Inc. executed the regional study with in-kind research and technical services from the Defense Health Resources Study Center (DHRSC).

The Establishment of a Community Health Planning Organization--MoReHEALTH emerged as a result of the Blue Ribbon Committee health care study.[28] In addition to assessing the impact of closing the SBHACH, the committee recommended the establishment of an ongoing mechanism or vehicle to assist in improving the health status of residents in the area. As an organization which has top leadership representation from all the area major health providers, as well as from large employers and governmental organizations, MoReHEALTH has been able to implement significant changes in this community.

CAPACITY FOR HEALTH CARE ASSESSMENT AND PLANNING

Communities affected by a base closure must develop a capacity to monitor and positively influence the adequacy, quality, and accessibility of health care in their communities. The following initiatives are indicative of the type of programs currently being pursued by MoReHEALTH in the Monterey region.

Continuing Care Retirement Community

MoReHEALTH has been working with FORA to implement a Continuing Care Retirement Community (CCRC). One of the findings reported in the Blue Ribbon Committee health care study was the need in the area for a retirement community for moderate income retirees.[29] As a result, MoReHEALTH notified prospective developers, implemented a Memorandum of Understanding with FORA (See Appendix I), and published a Request for Proposals. Additionally, MoReHEALTH identified criteria which were then used to pre-qualify bidders and recommend them to FORA. During the next 3-6 months it is anticipated that MoReHEALTH will assist FORA in the selection of a developer, as well as serve as liaison to facilitate implementation of the project. As this is the first reuse project implemented since FORA's establishment, the protocol established may serve as precedent for all future FORA activities.

VA Medical Center Outpatient Satellite Clinic and Other Partnerships

In MoReHEALTH's first year, the agency has assisted in the establishment of a VA outpatient clinic at Ft. Ord, which will be able to serve the 70,000 veterans in the area. This partnership, which was described in Chapter 4, is the beginning of an ongoing relationship between the Department of Veterans Affairs Medical Center at Palo Alto and the local community, on a variety of levels. Possible partners for the VA in the Monterey area include:

- Department of Defense--Sharing arrangements may be possible to serve the active duty military, civilians and families. The Army "footprint" on Ft. Ord as a new Presidio annex, and other military facilities in the area, encourage a natural relationship to partner, as reflected in the contract for AIDS testing of active duty beneficiaries already implemented.

- California State University, Monterey Bay and Monterey County--Joint activities with the VA in health promotion, disease prevention, and research programs are under discussion, as well as possible partnerships in health professions education and training.

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[28] *Monterey Regional Health Resources Strategy Study Report*, April 25, 1994, pg. 35.

[29] *Ibid.*, pg. 36.

- The private health care community-- may wish to participate with the VA on joint projects to serve target populations.

MoReHEALTH includes representation from all these organizations, and can continue to facilitate discussions to accomplish these ends. As a member of the MoReHEALTH board of directors, the VA is a vital partner in efforts to improve access to health care services in the Monterey region.

In summary, a national model applicable to other BRAC sites is being developed. The establishment of the VA outpatient clinic at Ft. Ord is only the first of several projects designed to improve health status in the region. After the clinic opens, it is anticipated that services will expand to other eligible groups. Negotiation and mediation will be necessary in most communities, between local providers, potential recipients, and governmental organizations. MoReHEALTH has a key role as community mediator for these discussions and potential organizational affiliations.

As discussed in Chapter 1, the DoD, VA and HCFA should join in a partnership with local community leaders to coordinate health and health care issues faced by the community and the DoD, early in the base closure process. This relationship should continue throughout the implementation of the process, and for a significant period after the facilities are closed, in order to address unanticipated consequences.

FINAL OBSERVATIONS

Applications of Lessons Learned

The Ft. Ord Base closure process was identified as a national model by the Secretary of Defense in September 1993. Members of the Defense Health Resources Study Center (DHRSC), and the Monterey Regional Health Development Group (MoReHEALTH), Inc. have worked together to facilitate the closure and reuse process, to document the activities experienced and to develop a capacity for ongoing health planning in this community. The publication of this *Lessons Learned* is a major move toward disseminating information throughout the nation, to assist other communities to anticipate what to expect from the closure experience, and to expedite their reuse activities.

Education

A next step is to develop mechanisms to educate communities affected by base closures. National and regional conferences are one way to educate communities. On April 22, 1995, a one-day symposium regarding the impact of base closures will be presented by representatives of MoReHEALTH and DHRSC in San Diego, California in conjunction with the Healthcare Forum's Annual Summit. Appendix J provides more information. It is anticipated that all communities previously affected by announcements of closures, as well as those receiving that news in the March round of announcements, will form an invitation pool for this conference.

Continuing Education

It should be expected that communities on the most recent lists of base closings will not be prepared to accept their inclusion as early as April of 1995. As many will still be in the period of *uncertainty* in April, a two-day conference is planned in Monterey, California in mid-August, 1995. This conference will be specifically designed for those communities included on the final list of BRAC 1995 sites, and could be replicated throughout the nation.

Ongoing Consultation

After August, 1995, the need will continue for communities to receive consultation assistance from representatives who have successfully survived a base closure. A pool of volunteers experienced in this activity could be available to assist the federal team, and to provide technical assistance to states and local communities throughout the nation in establishing mechanisms to deal with these changes in their communities. MoReHEALTH provides such a pool, and could develop a curriculum to train other community leaders as well.

Conclusion

Base closure and retrenchment may be traumatic and wrenching for the communities in which they occur. This is particularly so for the retirees and their family members left in an area after a facility closes. The Department of Defense has an opportunity to be a "good neighbor"--to work with the local leadership to plan for the future, even before a facility closes. DoD should also consider this as a continuing requirement extending a significant number of years into the future to ensure that replacement health care delivery systems are adequate. The information which can be developed from the data currently being collected by the Assistant Secretary of Defense for Health Affairs and the Defense Health Resources Study Center can clearly benefit other communities which are faced with similar major changes in the future.

Finally, the Monterey Regional Health Development Group (MoReHEALTH), Inc. has the opportunity not only to continue its community planning and development activities to improve health status and access in the Monterey region, but also to help ameliorate the shock and resulting inefficiencies experienced by other communities. As a national model, there is still much to learn and share from the Ft. Ord experience.

APPENDICES

FT. ORD AND SILAS B. HAYS ARMY HOSPITAL CLOSURE--LESSONS LEARNED

A. Ft. Ord Base Locator and Vicinity Maps

B. Charts of TRICARE Benefits and Coverage

C. Mission Statement of the California Medical Detachment, Monterey Bay Region

D. Excerpt from U. S. Army Medical Services Action Plan (MSAP) contained in the U.S. Army MEDDAC "After-Action" Report

E. Monterey Region Provider Network

F. Monterey Catchment Area

G. Military Health Services System (MHSS) Beneficiary, Pre-Closing and Post-Closing Survey instruments

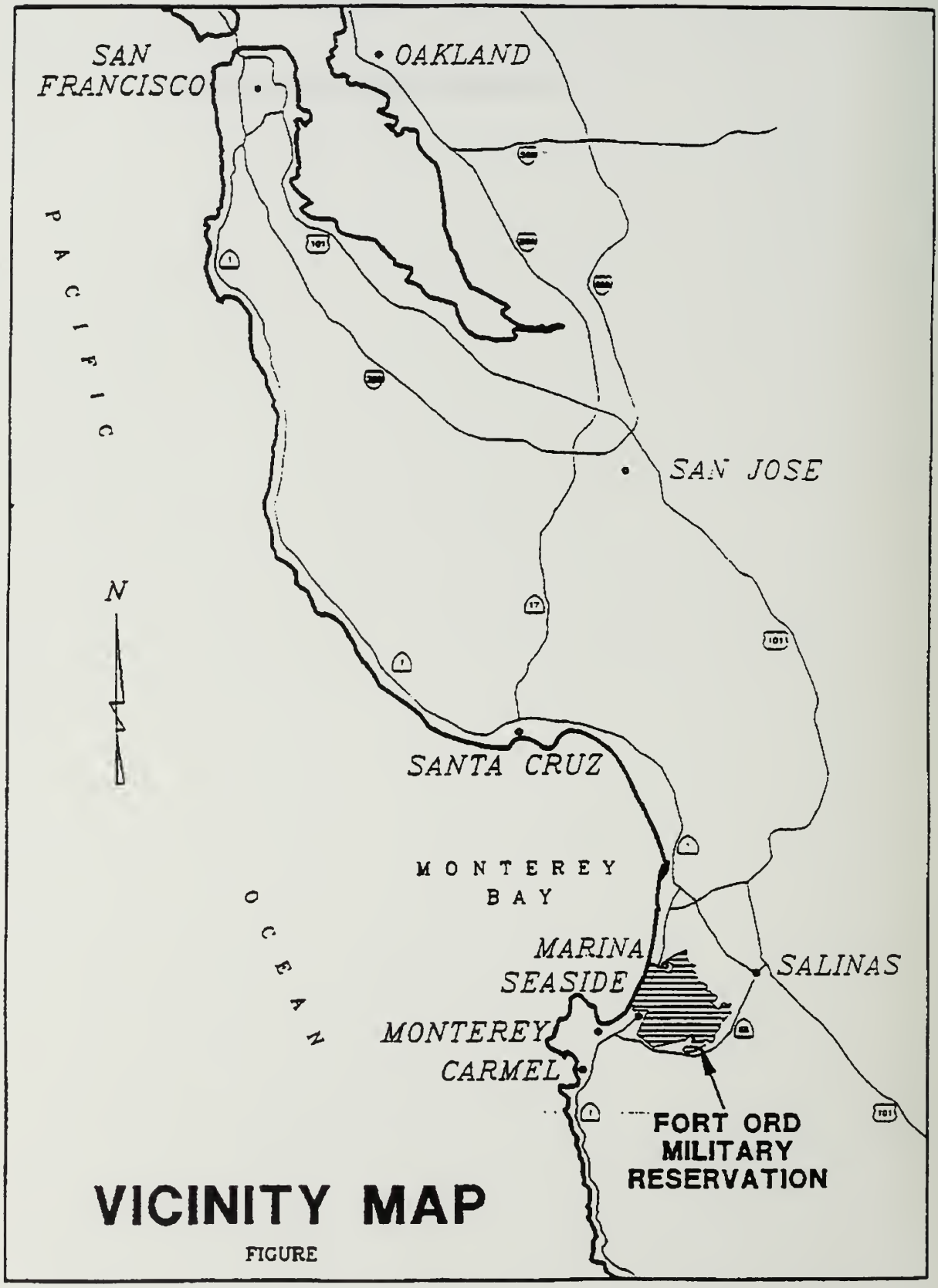
H. Department of Veterans Affairs Eligibility and Rate Schedules

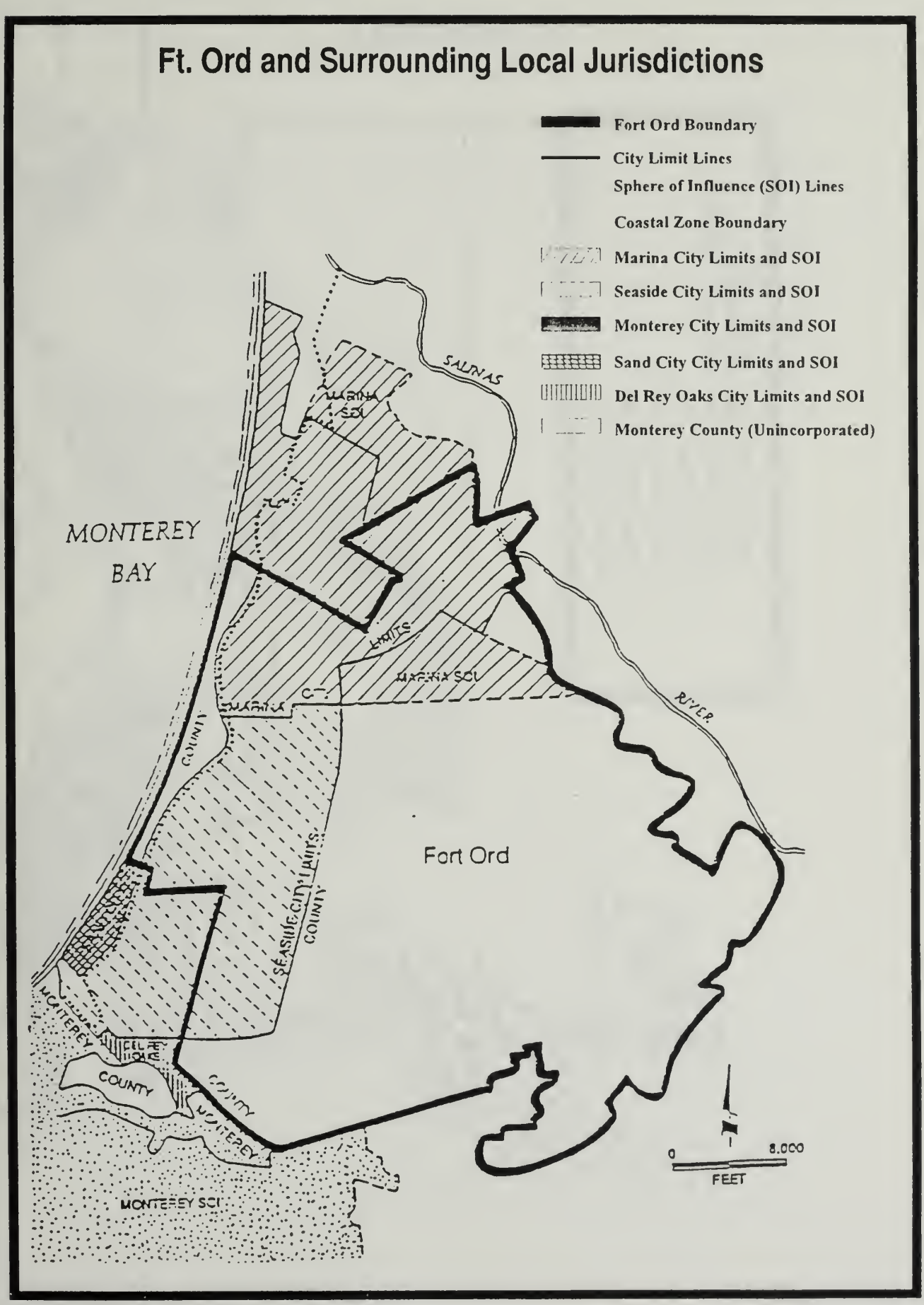
I. Memorandum of Understanding (MOU) between FORA and MoReHEALTH

J. Healthcare Forum *Healthier Communities* Conference scheduled for April 22-25, 1995

APPENDIX A

Ft. Ord Base Locator and Vicinity Maps


SAN FRANCISCO
OAKLAND
PACIFIC
SAN JOSE
N
SANTA CRUZ
MONTEREY BAY
OCEAN
MARINA
SEASIDE
SALINAS
MONTEREY
CARMEL
FORT ORD MILITARY RESERVATION
VICINITY MAP
FIGURE


Ft. Ord and Surrounding Local Jurisdictions
Fort Ord Boundary
City Limit Lines
Sphere of Influence (SOI) Lines
Coastal Zone Boundary
Marina City Limits and SOI
Seaside City Limits and SOI
Monterey City Limits and SOI
Sand City City Limits and SOI
Del Rey Oaks City Limits and SOI
Monterey County (Unincorporated)
MONTEREY BAY
SALINAS
MARINA SOI
LIMITS
MARINA SOI
SALINAS
RIVER
COUNTY
SEASIDE CITY LIMITS
COUNTY
Fort Ord
MONTEREY
COUNTY
COUNTY
MONTEREY
MONTEREY SOI
0
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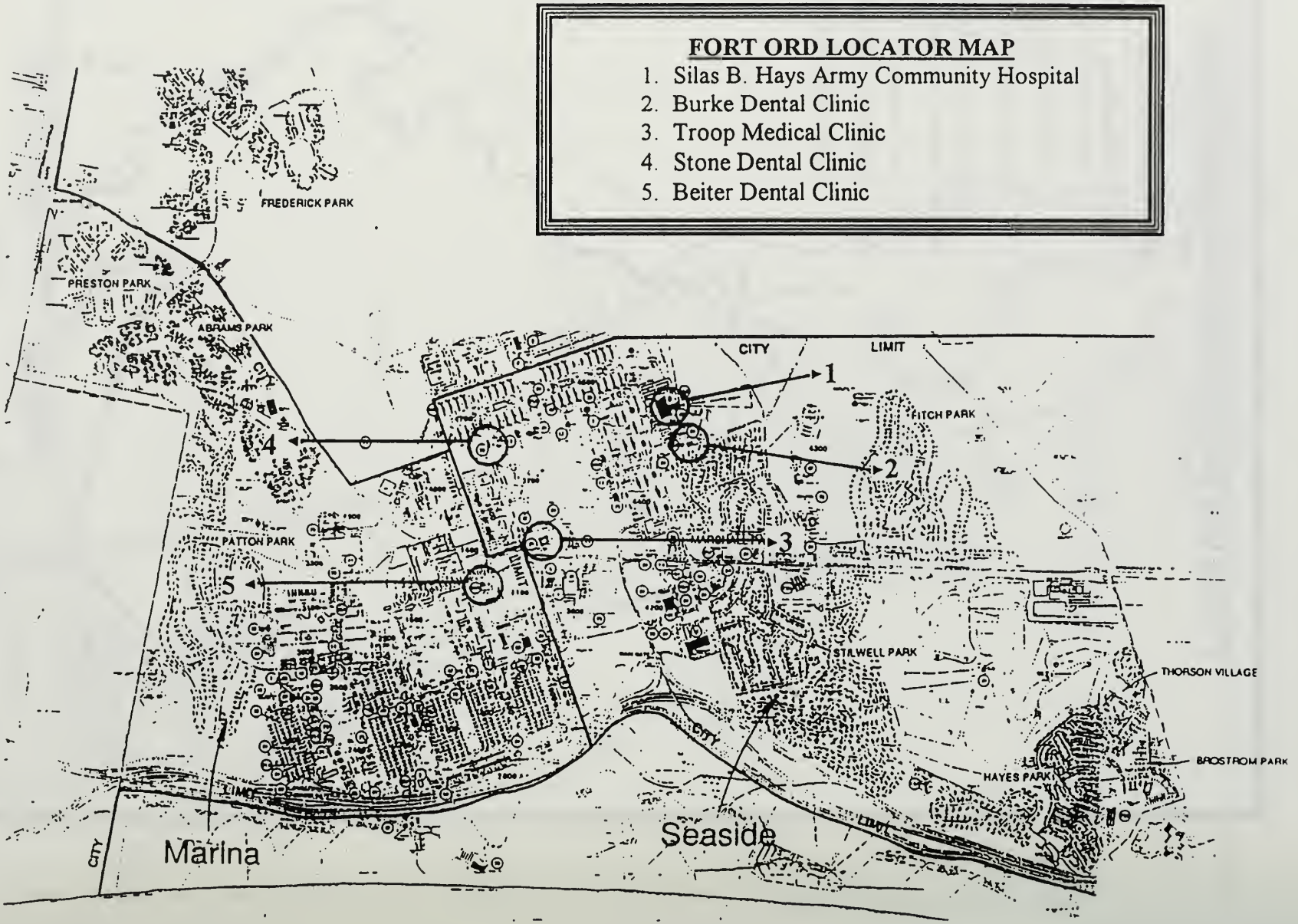
FEET

APPENDIX A


FORT ORD LOCATOR MAP
1. Silas B. Hays Army Community Hospital
2. Burke Dental Clinic
3. Troop Medical Clinic
4. Stone Dental Clinic
5. Beiter Dental Clinic
FREDERICK PARK
PRESTON PARK
ABRAMS PARK
PATTON PARK
CITY LIMIT
FITCH PARK
STILWELL PARK
THORSON VILLAGE
BROSTROM PARK
HAYES PARK
Marina
Seaside
1
2
3
4
5

APPENDIX B

Charts of TRICARE Benefits and Coverage

Benefits and Coverage Chart

Outpatient Services — Beneficiary Cost

SERVICES	TRICARE PRIME*	TRICARE EXTRA**	TRICARE STANDARD**
ANNUAL DEDUCTIBLE ** (Applied to Outpatient Services)	None	$150/person or $300/ Family per fiscal year.***	$150/person or $300/Family per fiscal year.***
PHYSICIAN SERVICES * + Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings and splints.	$5 copayment per visit.*	Active Duty Family Members: 15% of Plan allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: 20% of Plan allowable after deductible has been satisfied.	Active Duty Family Members: 20% of CHAMPUS allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: 25% of CHAMPUS allowable after deductible has been satisfied.
LABORATORY and X-RAY SERVICES (Including Mammograms.)	$5 copayment. (No copayment if included in the office visit.)		
ROUTINE PAP SMEARS Frequency depends on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology.	$5 copayment per visit. (No copayment if included in the office visit.)		
AMBULANCE SERVICES When medically necessary as currently defined and covered by OCHAMPUS.	$5 copayment per occurrence.		
EMERGENCY SERVICES Outpatient, both in and out of service area for emergency and urgently needed care.	$25 copayment for emergency room use. $15 copayment for urgent care center use.		
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, AND MEDICAL SUPPLIES PRESCRIBED BY YOUR PHYSICIAN AND WHEN A CHAMPUS BENEFIT (If dispensed for use outside of the office or after the home visit.)	10% of Plan allowable.		
HOME HEALTH CARE Part-time skilled nursing care, physical, speech and occupational therapy as currently defined by OCHAMPUS (when medically necessary).	$5 copayment per visit.		
FAMILY HEALTH SERVICES Family planning and well-baby care (up to 24 months of age). Certain exclusions apply as currently defined by OCHAMPUS.	$5 copayment per visit.		
OUTPATIENT MENTAL HEALTH One hour of therapy no more than two times each week (when medically necessary).	$10 copayment for individual visits. $5 copayment for group visits.		
Outpatient Medication Management.	$5 copayment per visit.		

* No copayment for primary care or preventive services for family members of sponsors with pay grades of E-4 and below (both active duty and retired). The Fiscal Intermediary has the responsibility for defining primary care; some office visits are subject to copayment(s).

** Please note that TRICARE Extra and TRICARE Standard annual deductibles and cost shares are subject to change.

*** Except for families whose Active Duty sponsor's pay grade is E-4 and below, for whom the annual deductible is $50/person or $100/family.

This is only a summary description of your coverage. Please see the Standard CHAMPUS Handbook and a TRICARE Prime Member Handbook for a more complete description of all terms and conditions. In addition, CHAMPUS regulations and interpretations under those regulations are the final authority on covered services.

\+ Certain outpatient procedures require a Non-availability Statement (NAS). You must obtain an NAS if you live within a designated service area near a military treatment facility if the care is not available at the facility. This may be a restricted NAS requiring you to use TRICARE network providers.

Benefits and Coverage Chart

Outpatient Services — Beneficiary Cost

SERVICES	TRICARE PRIME*	TRICARE EXTRA**	TRICARE STANDARD**
ANNUAL DEDUCTIBLE** (Applied to Outpatient Services)	None	$150/person or $300/ Family per fiscal year.***	$150/person or $300/Family per fiscal year.***
PRESCRIPTION DRUGS No charge for prescriptions at the military treatment facility.	$4 copayment per Rx up to a 30-day supply for Active Duty Family Members. $5 copayment per Rx up to a 30-day supply for Retirees, their Family Members, and Survivors.	Active Duty Family Members: 15% of Plan allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: 20% of Plan allowable after deductible has been satisfied.	Active Duty Family Members: 20% of CHAMPUS allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: 25% of CHAMPUS allowable after deductible has been satisfied.
EYE EXAMS One routine examination per year.	Active Duty Family Members: $5 copayment. Retirees and their Family Members and Survivors under age 18: $5 copayment. Retirees and their Family Members and Survivors 18 years of age and over: Not Covered.	Active Duty Family Members: 15% of Plan allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: Not Covered.	Active Duty Family Members: 20 % of CHAMPUS allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: Not Covered.
AMBULATORY SURGERY (same day)++ Authorized hospital-based or freestanding ambulatory surgical center that is CHAMPUS Certified.	+++Active Duty Family Members: No copayment. +++Retirees and their Family Members and Survivors: $5 copayment for primary surgeon only.	+++Active Duty Family Members: No copayment. +++Retirees and their Family Members and Survivors: 20% of Plan allowable after deductible has been satisfied.	Active Duty Family Members: $25 copayment for hospital charges. Retirees and their Family Members and Survivors: 25% of billed charges after deductible has been satisfied.
IMMUNIZATIONS Pediatric and adult immunizations as recommended by the American Academy of Pediatrics for children and by the U.S. Public Health Service for adults. If immunizations are needed for overseas travel, it is recommended you contact the military hospital or clinic and/or Public Health Department.	$5 copayment per visit up to 24 months of age. (See Family Health Services.) $5 copayment per immunization for over 2 years old.	For official travel, PCS orders outside the U.S. only. Active Duty Family Members: 15% of Plan allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: Not Covered.	For official travel, PCS orders outside the U.S. only. Active Duty Family Members: 20% of CHAMPUS allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: Not Covered.

* No copayment for primary care or preventive services for family members of sponsors with pay grades of E-4 and below (both active duty and retired). The Fiscal Intermediary has the responsibility for defining primary care; some office visits are subject to copayment(s).

** Please note that TRICARE Extra and TRICARE Standard annual deductibles and cost shares are subject to change.

*** Except for families whose Active Duty sponsor's pay grade is E-4 and below, for whom the annual deductible is $50/person or $100/family.

This is only a summary description of your coverage. Please see the Standard CHAMPUS Handbook and a TRICARE Prime member handbook for a more complete description of all terms and conditions. In addition, CHAMPUS regulations and the interpretations under those regulations are the final authority on covered services.

++ An outpatient Non-availability Statement may be required. Consult your Health Care Finder. This may be a restricted NAS requiring you to use TRICARE network providers.

+++ With authorization.

For Active Duty Family Members, the maximum family liability (Catastrophic Cap Benefit) is $1000 for deductibles and cost-shares based on allowable charges for the Basic Program services and supplies received in a Fiscal Year. For all other beneficiary families, the Fiscal Year cap is $7,500. After a Fiscal Year cap is met, the CHAMPUS-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program received through the end of that Fiscal Year. In order to get credit for all family expenditures allowed toward the Catastrophic Cap benefit, the beneficiary may be required to submit appropriate documentation (e.g., CHAMPUS Explanation of Benefits).

Benefits and Coverage Chart

Outpatient Services — Beneficiary Cost

SERVICES	TRICARE PRIME*	TRICARE EXTRA**	TRICARE STANDARD**
ANNUAL DEDUCTIBLE** (Applied to Outpatient Services)	None	$150/person or $300/ Family per fiscal year.***	$150/person or $300/Family per fiscal year.***
PARTIAL HOSPITALIZATION FOR ALCOHOLISM TREATMENT Up to 21 days for rehabilitative treatment on a limited hour-per-day basis. Does not count toward the mental health inpatient limit, but does count toward 60-day partial hospitalization limit.	Subject to inpatient mental health copayment.	Subject to inpatient mental health copayment.	Subject to inpatient mental health copayment.
PARTIAL HOSPITALIZATION FOR PSYCHIATRIC TREATMENT Limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. Not counted toward the 30/45 day inpatient limit.	Subject to inpatient mental health copayment.	Subject to inpatient mental health copayment.	Subject to inpatient mental health copayment.
PERIODIC PHYSICAL EXAMINATIONS Conducted by Primary Care Manager for ages over 24 months. For well-baby care up to 24 months of age, see "Family Health Services."	$5 copayment per physical for ages 2-6. $15 copayment per physical for ages 7and older.	Not covered.	Not covered.
PHYSICAL, OCCUPATIONAL, SPEECH AND RADIATION THERAPY	$5 copayment per visit.	Active Duty Family Members: 15% of Plan allowable after deductible has been satisfied. Retirees and their Family Members and Survivors: 20% of Plan allowable after deductible has been satisfied.	Active Duty Family Members: 20% of CHAMPUS allowable after deductible has been satisifed. Retirees and their Family Members and Survivors: 25% of CHAMPUS allowable after deductible has been satisfied.
WELLNESS CLASSES, COMMUNITY HEALTH SERVICES AND COMMUNITY RESOURCE COORDINATION	No charge or minimal cost.	No charge or minimal cost.	No charge or minimal cost.

* No copayment for primary care or preventive services for family members of sponsors with pay grades of E-4 and below (both active duty and retired). The Fiscal Intermediary has the responsibility for defining primary care; some office visits are subject to copayment(s).

** Please note that TRICARE Extra and TRICARE Standard annual deductibles and cost shares are subject to change.

*** Except for families whose Active Duty sponsor's pay grade is E-4 and below, for whom the annual deductible is $50/person or $100/family.

This is only a summary description of your coverage. Please see the Standard CHAMPUS Handbook and a TRICARE Prime member handbook for a more complete description of all terms and conditions. In addition, CHAMPUS regulations and the interpretations under those regulations are the final authority on covered services.

++ An outpatient Non-availability Statement may be required. Consult your Health Care Finder. This may be a restricted NAS requiring you to use TRICARE network providers.

+++ With authorization.

For Active Duty Family Members, the maximum family liability (Catastrophic Cap Benefit) is $1000 for deductibles and cost-shares based on allowable charges for the Basic Program services and supplies received in a Fiscal Year. For all other beneficiary families, the Fiscal Year cap is $7,500. After a Fiscal Year cap is met, the CHAMPUS-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program received through the end of that Fiscal Year. In order to get credit for all family expenditures allowed toward the Catastrophic Cap benefit, the beneficiary may be required to submit appropriate documentation (e.g., CHAMPUS Explanation of Benefits).

Benefits and Coverage Chart

Inpatient Services — Beneficiary Cost

SERVICES	TRICARE PRIME	TRICARE EXTRA	TRICARE STANDARD
HOSPITALIZATION++ Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-rays and other radiology services, necessary medical supplies and appliances, blood and blood products.	+ Active Duty Family Members: No copayment. + Retirees and their Family Members and Survivors: No copayment for professional services. $75 per day to $750 maximum per admission.	+ Active Duty Family Members: No copayment. + Retirees and their Family Members and Survivors: copayment of $125 per day or 25% of plan allowable, whichever is less, plus 20% of separately billed professional charge at Plan allowable rate.	Active Duty Family Members: $25 copayment or $9.30*** per day whichever is higher. + Retirees and their Family Members and Survivors: copayment of $271*** per day or 25% of billed charges, whichever is less, plus 25% of CHAMPUS allowable for separately billed professional charges.
MATERNITY ++ Hospital and professional services (prenatal, postnatal).			
SKILLED NURSING FACILITY CARE Semiprivate room, regular nursing services, meals including special diets, physical, occupational, and speech therapy, drugs furnished by the facility, necessary medical supplies, and appliances.			Active Duty Family Members: $25 copayment or $9.30*** per day, whichever is higher. Retirees and their Family Members and Survivors: 25% of billed charges, plus 25% of CHAMPUS allowable for separately billed professional charges.
HOSPITALIZATION FOR MENTAL ILLNESS ++ 18 and under, 45 days per year. 19 and older, 30 days per year as medically necessary. Up to 150 days for treatment in a Residential Treatment Center. The number of days may be subject to change pending new legislation.	+++ Active Duty Family Members: No copayment for civilian hospital. +++ Retirees and their Family Members and Survivors: copayment of $50 per day or 25% of Plan allowable, whichever is less.	+++ Active Duty Family Members: No copayment for civilian hospital. +++ Retirees and their Family Members and Survivors: copayment of $50 per day or 25% of Plan allowable, whichever is less, plus 20% of separately billed professional charge at Plan allowable rate.	Active Duty Family Members: $25 copayment or $9.30*** per day, whichever is higher. Retirees and their Family Members and Survivors: 25% of CHAMPUS allowable charges, plus 25% of CHAMPUS allowable for separately billed professional charges.
ALCOHOLISM ++ 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward 30-day limit for mental health benefits.			

*** This figure is for Fiscal Year 1994 and is subject to change each October 1 at the beginning of each Fiscal Year.

This is only a summary description of your coverage. Please see the Standard CHAMPUS Handbook and a TRICARE Prime member handbook for more complete description of all terms and conditions. In addition, CHAMPUS regulations and the interpretations under those regulations are the final authority on covered services.

\+ Unlimited, with authorization, as medically necessary.

++ NAS Note: You must obtain a Non-availability Statement if you live within a designated service area around a military hospital. This may be a restricted NAS requiring you to use TRICARE network providers.

+++ With authorization.

For Active Duty Family members, the maximum family liability (Catastrophic Cap Benefit) is $1000 for deductibles and cost-shares based on allowable charges for the Basic Program services and supplies received in a Fiscal Year. For all other beneficiary families, the Fiscal Year cap is $7,500. After a Fiscal Year cap is met, the CHAMPUS-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program received through the end of that Fiscal Year. In order to get credit for all family expenditures allowed toward the Catastrophic Cap Benefit, the beneficiary may be required to submit appropriate documentation (e.g. CHAMPUS Explanation of Benefits).

APPENDIX C

Mission Statement of the
California Medical Detachment, Monterey Bay Region

Mission Statement
California Medical Detachment (CMD)

1. **Mission:**

- **For Active Duty Military**

  -- Provide Primary Outpatient and Preventive Health Care
  -- Coordinate/Contract Specialty Outpatient Health Care
  -- Coordinate Inpatient Health Care

- **For Department of Army/DOD Civilians**

  -- Provide AR 40-5/DOD Equivalent Occupational Medicine Support

- **For Active Duty Family Members and Retirees**

  -- Assist in Health Care Coordination with TRICARE Managed Care Support Program Contractor (AETNA) and/or MEDICARE Program Representatives

  -- As Resources Permit, Provide Outpatient and Preventive Health Care on a Space Available Basis

2. **Support Area:**

- Presidio Monterey/Naval Postgraduate School
- Fort Hunter Liggett/Camp Roberts
- Sierra Army Depot
- Hawthorne Army Depot
- Oakland Army Base
- Presidio San Francisco
- Sharp/Tracy Army Depots (Environmental Health only)
- Camp Parks (Environmental Health only)

3. **Functional Element Guidance:** Each CMD Clinic establishes defined managed care tracks with its local civilian health care system and its nearest regional DOD or VA inpatient hospital facility to achieve the best mix of access to cost-effective, quality health care. Consequently, each CMD clinic develops local policies and procedures regarding the following areas:

- Active Duty Outpatient Care (e.g., sick call, routine appointments, specialty care management and referrals, urgent/emergent care, etc.).

- Active Duty Inpatient Care (e.g., referral procedures to local hospital/convalescent center for stabilization/overnight observation, nearest military or VA hospital, how and when to transfer, etc.)

- Family Member of Active Duty Outpatient care (e.g., interaction with TRICARE Service Center, Resource Sharing/Cooperative Care, management of space available appointments, extent of pharmacy services, etc.)

- Family Member of Active Duty Inpatient Care (TRICARE) Service Center/ Hospital Network,, availability at DOD hospital facility, etc.)

- Retiree Outpatient Care (see Family Member above)

- Retiree Inpatient Care (see Family Member above)

- Evacuation Policies (duty hour and non-duty hour, ground and air, etc.)

- Emergency Preparedness Plan/Alert Rosters

APPENDIX D

Excerpt from U. S. Army Medical Services Action Plan (MSAP)
contained in the U.S. Army MEDDAC "After-Action" Report

U. S. ARMY MEDICAL SERVICES ACTION PLAN

The following is an extract from the final Medical Services Action Plan (MSAP). The MSAP was a very fluid document and required five revisions to address the changing environment in which the MEDDAC had to maneuver for closure.

1. **SITUATION:** The President recommended to Congress the closure of Ft. Ord, California and with Congressional action Ft. Ord was selected for closure in the BRAC 91 process. The 7th Infantry Division (Light) has moved the 9th Regiment to Ft. Lewis, Washington and deactivated the remaining two brigades during calendar year 1993. A residual of approximately 1,500 soldiers will remain during a portion of FY94 to assist in the closure of Ft. Ord. Ft. Hunter-Liggett and the Presidio of Monterey are currently scheduled to remain operational.

   A. Supported Installations and Activities--U.S. Army Medical Department Activity (MEDDAC), Ft. Ord provide area health support to the California counties of Fresno, Kern, Kings, Los Angeles, Madera, Mariposa, Merced, Monterey, Orange, San Benito, San Luis Obispo, Santa Barbara, Tulare, Ventura, including Reserve Components support for Camp Roberts. Medical Treatment Facilities (MTF) include: Silas B. Hays, U.S. Army Community Hospital, Ft. Ord; U.S. Army Health Clinic (AHC), Ft. Hunter-Liggett; U.S. Army Health Clinic (AHC), Presidio of Monterey. The major tenant activity on the Presidio of Monterey is the Defense Language Institute (for which the Army is the executive agent). The Naval Postgraduate School and the U.S. Coast Guard Group, Monterey, also rely on services provided by the MEDDAC/DENTAC, Ft. Ord.

   B. The U.S. Army Health Services Command (HSC) organization responsible for preparing this Medical Services Action Plan (MSAP)--MEDDAC, Ft. Ord.

   C. Assumptions--

      (1) A portion of the deactivated 7th Infantry Division (Light) will remain, as Ft Ord Garrison, to assist in closure and will depart NLT 3rd Qtr FY94.

      (2) The MEDDAC will reduce health care services commensurate with the remaining active duty's departure and the residual active duty population.

      (3) Projected active duty beneficiary populations (all services) after FY95: 5 at Ft. Ord; 570 at Ft. Hunter-Liggett; 3,500 at Presidio of Monterey; and 2,409 at the Naval Postgraduate School and the U.S. Coast Guard Group, Monterey.

      (4) Outpatient services will continue at Ft. Hunter-Liggett and the Presidio of Monterey.

      (5) The responsibility for the Ft. Ord Health Service Area will transfer to the California Medical Detachment (CMD), with Madigan Army Medical Center (MAMC) as the regional headquarters. This transfer includes the missions for Preventive Medicine services, Veterinary services, and Biomedical Equipment Maintenance and Repair services. The effective date will be no later than April 1, 1994.

      (6) Responsibility for health services area support to the reserve components at Ft. Ord within the AR 5-9, Intra-service Support Installation Area Coordination, will transfer to MAMC, Ft Lewis, WA, not later than 1 April 1994.

(7) Responsibility for the Army Health Clinic at POM will transfer to the California Medical Detachment on November 1, 1993.

(8) Responsibility for direct health services for any reserve enclave under the provisions of paragraph 4-2, AR 40-3, Medical, Dental, and Veterinary Care, and in accordance with the FORSCOM-TRADOC-HSC MOU will transfer to MAMC, Ft. Lewis, WA. The effective date will be not later than April 1, 1994.

(9) The civilian health care system in the area (Monterey County) has sufficient capacity to support the remaining beneficiaries. However, given the current climate of the local area, it will require a sensitive and concerted effort., by the Army, to ensure acceptance of this proposal.

(10) The closest inpatient military treatment facility is the U.S. Navy Hospital, Oakland (selected for closure in BRAC 93 legislation). The Presidio of San Francisco will close under BRAC I. LUSAH (Letterman U.S.Army Hospital) will downsize to a U.S. Army Health Clinic on September 1993.

(11) The closest Veterans Administration Hospital is approximately 80 miles from Ft. Ord.

(12) Approximately 1,500 housing units, commissary and PX, police, fire department and gas station will remain, as a POM annex, on Ft Ord.

2. **MISSION:** To provide appropriate direct health services to the beneficiary population within the Ft. Ord Health Services Area as the Army medical force structure is realigned and Ft. Ord is closed.

3. **EXECUTION:**

A. Concept of Operation--The MEDDAC, Ft. Ord reduced inpatient care services on 1 Jul 93 to fifty beds with closure of all inpatient abilities NLT 31 Mar 94. SBHACH will convert to an Army Health Clinic, 1 Apr 1994 with Outpatient services continuing until, but NLT, 30 Jun 94. The mix of services will be determined by the physician specialty available and the migration of Army medical force structure. When inpatient services terminate at Ft. Ord, responsibility for the health services area will transfer to MAMC, Ft. Lewis, WA via the CMD. It will be necessary for the remaining DoD agencies to negotiate arrangements for the provision of inpatient care.

B. Milestones--Milestones for required tasks will be further delineated as guidance from HQ HSC and FORSCOM becomes more definitive.

FY93--	Jul 93	SBHACH to 50 operating beds (includes cribs), ORs to 2 rms, ICU to 2 Specialty Beds with Recovery Room and Same Day Surgery
	Sep 93	OB/L&D/NBN closed

FY94-- Resources for Ft Ord MEDDAC will be available.
SBHACH 50 Bed facility (basic Medical/Surgical wards).
1st/2nd Qtr FY94 Non-Division Troops depart.

Nov 93	Specialty Beds closed
Dec 93	ER to an Acute Care Clinic
Mar 94	SBHACH Inpatient Services closed
Apr 94	SBHACH to an Army Health Clinic, Return Certificate of Accreditation to JCAHO
Jun 94	SBHACH Outpatient Services Closed
1 Jul 94	SBHACH Decommissioned

C. Medical construction required to support action--To Be Determined

D. Medical treatment facilities disposition--To Be Determined.

E. OMA/CHAMPUS cost impact--Reference memorandum, HQDA, DACS-DMB, 23 July 1991, subject: Headquarters, Department of the Army Base Realignment and Closure Financial Management Implementation. USA MEDDAC/DENTAC, Ft. Ord will provide this under separate cover.

APPENDIX E

Monterey Region Provider Network

Medical Services and Providers
(Foundation Health Group versus Aetna Government Health)

Benefits/Physician Comparison	Foundation	Aetna
I. Primary Care Physicians	Number of	Physicians
Cardiology	-	4
Emergency Medicine	-	4
Endocrinology & Metabolism	-	3
Family Practice	16	35
General Practice	-	14
Gynecology	-	4
Internal Medicine	11	27
Neonatology	-	1
Nephrology	-	3
Obstetrics	-	1
Obstetrics & Gynecology	1	12
Pediatrics	[illegible]	15
Pediatrics Allergy	-	1
Pediatrics Cardiology	-	1
Preventive Medicine	-	5
Pulmonary Medicine	-	4
Rheumatology	-	7
Primary Care Total:	34	135
II. Specialty Providers		
Allergy	[illegible]	4
Anesthesiology	-	1
Cardiology	[illegible]	13
Emergency Medicine	-	7
Endocrinology & Metabolism	-	4
Family Practice	16	4
Gastroenterology	-	3
General Practice	-	8
Genetics	-	1
Geriatrics	-	2

Specialty Providers	Foundation	Aetna
Continued	Number of	Physicians
Gynecology	1	3
Hematology/Oncology	-	3
Infectious Disease	-	7
Internal Medicine	18	35
Neonatology	-	7
Nephrology	2	4
Neurology	-	3
Obstetrics	-	1
Obstetrics & Gynecology	6	14
Occupational Medicine	-	1
Oncology	-	3
Ophthalmology	8	1
Orthopedics	4	14
Otolaryngology	2	7
Pathology	1	1
Pediatrics	8	1
Pediatrics Allergy	-	7
Pediatrics Cardiology	-	1
Podiatry	4	12
Preventive Medicine	-	4
Pulmonary Medicine	1	5
Radiation Oncology	-	1
Radiation Therapy	1	7
Radiology Diagnostic	2	1
Rheumatology	-	2
Surgery General	1	15
Surgery Specialists	6	14
Urology	2	15
Specialty Provider Total:	91	225

APPENDIX E

APPENDIX F

Monterey Catchment Area

MONTEREY CATCHMENT AREA

(40 Mile Radius)

ZipCodes	Area	Zipcodes	Area
93901	Salinas	95010	Capitola
93902	Salinas	95012	Castroville
93905	Salinas	95013	Cyote
93906	Salinas	95017	Davenport
93907	Salinas-Prunedale	95018	Felton
93908	Salinas	95019	Freedom
93911	Salinas	95020	Gilroy
93912	Salinas	95021	Gilroy
93915	Salinas	95023	Hollister
93920	Big Sur	95024	Hollister
93921	Carmel	95026	Holy City
93922	Carmel	95032	Los Gatos
93923	Carmel	95037	Morgan Hill
93924	Carmel Valley	95038	Morgan Hill
93925	Chular	95039	Moss-Landing
93926	Gonzales	95041	Mt. Hermon
93927	Greenfield	94042	New Almadean
93933	Marina	95043	Paicines
93940	Monterey	95044	Redwood Estates
93941	Fort Ord	95045	San Juan Bauista
93942	Monterey (box)	95046	San Martin
93943	USN (NPS)	95060	Santa Cruz
93944	Monterey-Presido/DLI	95061	Santa Cruz
93950	Pacific Grove	95062	Santa Cruz
93953	Pebble Beach	95063	Santa Cruz
93955	Seaside	95064	Santa Cruz
93960	Soledad	95065	Santa Cruz
93962	Spreckles	95066	Scotts Valley
95001	Aptos	95067	Scotts Valley
95003	Aptos	95073	Soquel
95004	Aromas	95075	Tres Pinos
95005	Ben Lomond	95076	Watsonville
95006	Boulder Creek	95077	Watsonville
95007	Brooksdale	95120	San Jose

Total: 68 zipcodes

APPENDIX G

Military Health Services System (MHSS) Beneficiary
Pre-Closing and Post-Closing Survey instruments

HEALTH CARE QUESTIONNAIRE

When completing the questions below, please keep the following definitions in mind.

Military Medical Treatment Facility (MTF): any military hospital or clinic. **It does not include VA facilities.**

Civilian Hospital/Clinic: any hospital or clinic open to the general civilian population.

CHAMPUS: includes CHAMPUS, CHAMPUS PRIME or EXTRA and any deductibles or copayments that you may personally pay.

Private Payment: any private medical insurance such as Blue Cross, Prudential or insurance that is paid by an employer or family member. Also includes the use of personal funds to pay for health care.

Health care provider: any doctor, nurse or other medical personnel.

Phone Response

Please respond by calling

1-800-883-4772

Follow the instructions provided.

Mail Response

If you choose to respond by mail, darken the square for each question and return your questionnaire in the postage paid envelope provided.

- **Use a No. 2 lead pencil only.**
- **Do not use ink or ballpoint pen.**
- **Make heavy dark marks that fill the square.**
- **Erase cleanly any answer you wish to change.**
- **Make no stray marks.**

IMPORTANT

Please respond to the following questions as they apply to the person to whom the questionnaire is addressed.

1. **Please enter the 7-digit access number that appears above the mailing address.**

☐ ☐ ☐ ☐ ☐ ☐ ☐

2. **Do you have any medical insurance/coverage other than CHAMPUS or CHAMPUS Supplemental Insurance? (This means medical insurance paid for by your employer or yourself or medical coverage such as MEDICARE/MEDICAID).**

Yes	No
1	2

3. **During the past 6 months, did you stay in a hospital overnight?**

Yes	No
1	2

→ **Go to Question 4**

I spent the following number of nights in a:

	None	1	2	3	4	5	6	7	8	9+
a. Military Hospital	0	1	2	3	4	5	6	7	8	9
b. Civilian hospital-CHAMPUS	0	1	2	3	4	5	6	7	8	9
c. Civilian hospital-private payment or other	0	1	2	3	4	5	6	7	8	9

446398

DO NOT WRITE IN THIS SHADED AREA

4. During the past 6 months, did you have an office visit with a doctor, nurse or other medical professional?

Yes [1] No [2] → Go to Question 5

I had the following number of office visits with the following health care provider(s) listed below:

	None	1	2	3	4	5	6	7	8	9+
a. Military provider	0	1	2	3	4	5	6	7	8	9
b. Civilian provider-CHAMPUS	0	1	2	3	4	5	6	7	8	9
c. Civilian provider-private payment or other	0	1	2	3	4	5	6	7	8	9

5. During the past 6 months, did you fill or refill any prescriptions?

Yes [1] No [2] → Go to Question 6

I filled or refilled the following number of prescriptions at the pharmacy(s) listed below:

	None	1	2	3	4	5	6	7	8	9+
a. Military pharmacy	0	1	2	3	4	5	6	7	8	9
b. Civilian pharmacy-CHAMPUS	0	1	2	3	4	5	6	7	8	9
c. Civilian pharmacy-private payment or other	0	1	2	3	4	5	6	7	8	9

6. Overall, how satisfied are you with the health care services you have received during the last 6 months from a:

	Does Not Apply	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied
a. Military health care facility/provider	0	1	2	3	4	5
b. Civilian facility/provider paid by CHAMPUS	0	1	2	3	4	5
c. Civilian facility/provider paid by private payment	0	1	2	3	4	5

7. Overall, how would you describe your health?

Excellent [1] Very Good [2] Good [3] Fair [4] Poor [5]

8. Please enter your zip code (if you are completing this survey for a family member, enter their zip code).

☐ ☐ ☐ ☐ ☐

NOTE: If responding by mail, please fill in this grid.

Write the zip code in the boxes. →

Then fill in the matching circles below each box. →

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

THIS COMPLETES THE QUESTIONNAIRE - PLEASE RESPOND BY FEBRUARY 18.

R8168-PFI-54321

INSTRUCTIONS

- There are two ways to answer this short questionnaire.
- **Please respond right away.**

We would prefer you dial our TOLL-FREE telephone number from a touch-tone phone and respond to the questions read to you. This takes 4-5 minutes. You respond by pressing the telephone keys indicated. You may call 24 hours a day, 7 days a week.

BEFORE CALLING, PLEASE HAVE READY:

- **YOUR ANSWERS TO THE QUESTIONS, AND**
- **THE 7-DIGIT ACCESS NUMBER LOCATED ABOVE THE NAME ON THE FRONT PAGE OF THIS BOOKLET.** This number is required to record your answers.

Dial **1-800-656-2944** and have answers and survey access number ready.

OR

If you do not have a touch-tone telephone or touch-tone service, or you prefer not to respond by phone, you may mail your response.

- Use a **No. 2 pencil only.**
  - Do not use ink or ballpoint pen; make no stray marks.
  - Make heavy dark marks that fill the square for each question.
  - Erase cleanly any answer you wish to change.
- Separate questionnaire along perforated line.
- Return your questionnaire in the pre-addressed, postage-paid envelope.

If you respond by telephone, please do not mail your survey.

DEFINITIONS

When completing the questions, please keep in mind these definitions:

- **Military Medical Treatment Facility (MTF):** any military hospital, clinic, or PRIMUS/NAVCARE clinic. It does not include VA facilities.
- **Civilian Hospital/Clinic:** any hospital or clinic open to the general civilian population.
- **CHAMPUS/TRICARE:** includes "Standard," "Prime," and "Extra" options, and any deductible co-payments you pay associated with these programs.
- **Private Payment:** any private medical insurance such as Blue Cross, Prudential, or insurance that is paid wholly or partially by an employer or family member (including MEDICARE and MEDICAID). Also includes the use of personal funds to pay for health care.
- **Health care provider:** any doctor, nurse, or other medical personnel.

HEALTH CARE QUESTIONNAIRE

Phone Response OR **Mail Response**

Please respond by calling **1-800-656-2944**
Follow the directions provided.

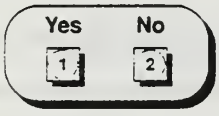
Use #2 Pencil to darken the squares.
Mail in post-paid envelope provided.

IMPORTANT

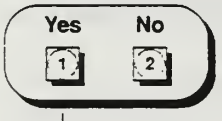
Please respond to the following questions as they apply to the person to whom the questionnaire is addressed.

1. Enter the 7-digit access number located above the name and address on the front page of this booklet.

2. Do you have any medical insurance/coverage other than CHAMPUS or CHAMPUS Supplemental Insurance? (This means medical insurance paid for by your employer or yourself or medical coverage such as MEDICARE/MEDICAID).

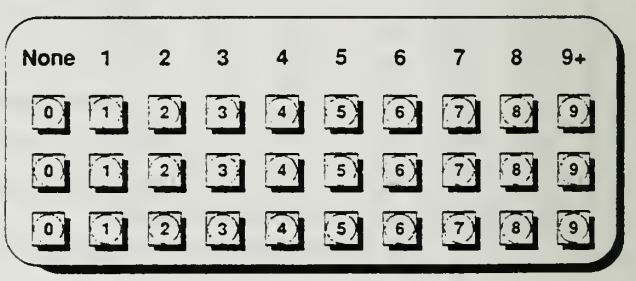


3. During the past 6 months, did you stay in a hospital overnight?

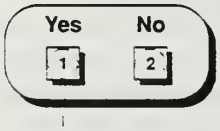


→ Go to Question 4

I spent the following number of nights in a:

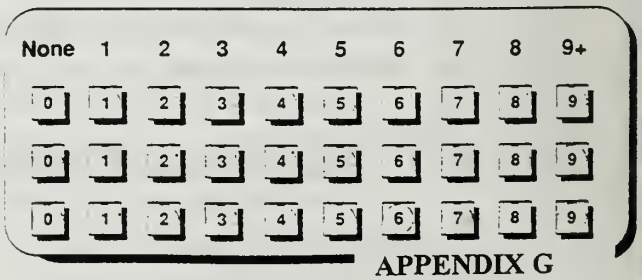


4. During the past 6 months, did you have an office visit with a doctor, nurse, or other medical professional?



→ Go to Question 5

I had the following number of office visits with the health care provider(s) listed below:



5. **During the past 6 months, did you fill or refill any prescriptions?**

Yes	No
1	2

→ Go to Question 6

I filled or refilled the following number of prescriptions at the pharmacy(s) listed below:

	None	1	2	3	4	5	6	7	8	9+
a. Military pharmacy	0	1	2	3	4	5	6	7	8	9
b. Civilian pharmacy-CHAMPUS	0	1	2	3	4	5	6	7	8	9
c. Civilian pharmacy paid by private payment, or Veterans hospital pharmacy	0	1	2	3	4	5	6	7	8	9

6. **If you needed medical care during the next 6 months, where would you most likely go to obtain it? (Please choose only one)**

a. Military health care facility/provider	1
b. Civilian health care facility/provider paid by CHAMPUS	2
c. Civilian health care facility/provider paid by private payment, or Veterans hospital/clinic	3

7. **Overall, how satisfied are you with the health care services you have received during the last 6 months from a:**

	Does Not Apply	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied
a. Military health care facility/provider	0	1	2	3	4	5
b. Civilian health care facility/provider paid by CHAMPUS	0	1	2	3	4	5
c. Civilian health care facility/provider paid by private payment, or Veterans hospital/clinic	0	1	2	3	4	5

8. **Overall, how would you describe your health?**

Excellent	Very Good	Good	Fair	Poor
1	2	3	4	5

THIS COMPLETES THE QUESTIONNAIRE - THANK YOU.

POST-CLOSING SURVEY

APPENDIX G

APPENDIX H

Department of Veterans Affairs Eligibility and Rate Schedules

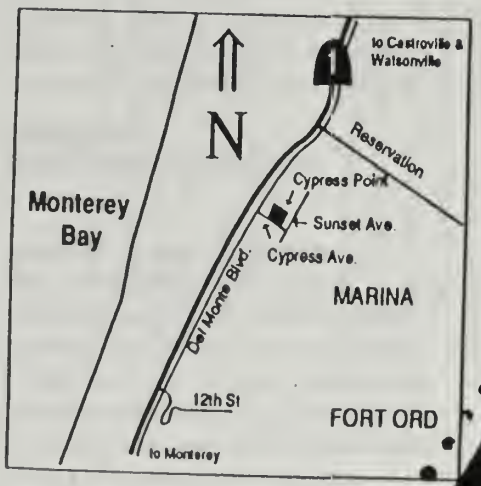
THE VA CLINIC OF MONTEREY

Address: 3056 Del Monte Blvd., Suite 205 Marina, CA 93933 (Reservation Rd. exit from Hwy. 1 in the Cypress Point Center. Located at the corner of Del Monte Blvd. and Cypress Ave., behind the Taco Bell)

Telephone # (408) 393-2654

Fax #: (408) 384-5233

Hours of Operation: 8:00 am - 5:00 pm (Monday through Friday except holidays)



APPENDIX H

THE VA CLINIC OF MONTEREY
3056 Del Monte Blvd.,
Suite 205
Marina, CA 93933

VA Clinic of Monterey

Veterans Affairs Medical Center
Palo Alto, California

Affiliated with Stanford University
School of Medicine

Who are we?

The VA Clinic of Monterey is operated by the Palo Alto Veterans Affairs Medical Center. Our mission is to meet the clinical needs of all eligible veterans. Clients under our care have access to all the services of the world renowned Palo Alto Veterans Affairs Medical Center, which is affiliated with Stanford University School of Medicine.

What services will be available?

VA Clinic of Monterey offers primary medical care and treatment, as well as referrals to Palo Alto Veterans Affairs Medical Center specialists and clinics. Laboratory and X-ray services, drug abuse and preventive health programs, and a pharmacy also are available. Dental programs, medical/surgical specialty clinics, rehabilitative services and other activities to meet our patient's needs are being planned for Monterey and are currently available at the VA Medical Center in Palo Alto.

Who is eligible for care at the VA Clinic of Monterey?

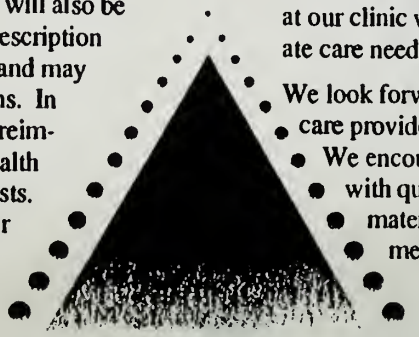
Though federal laws still limit which veterans and their dependents are eligible for care, we invite you to phone (408) 383-2654 for further information about eligibility, to register or to make an appointment. Or you can write us at:

Veterans Affairs Medical Center
Clinic of Monterey
3056 Del Monte Blvd., Suite 205
Marina, CA 93933

We will assist you in the process of qualifying for care and treatment at the VA Clinic of Monterey. Veterans who have received private medical care in the Monterey area at VA expense should now use the VA Clinic of Monterey as their primary health care site.

What will it cost?

Many eligible veterans will not be charged for VA Clinic of Monterey visits, medications, laboratory tests, or hospitalization and treatments at the Palo Alto Veterans Affairs Medical Center. Other patients, after financial evaluation, will be billed a fixed clinic visit fee of $36.00 per visit which includes all professional charges and laboratory tests. These patients will also be assessed a $2.00 fee for each prescription they fill through our pharmacy and may incur charges for hospitalizations. In some cases, you may apply for reimbursement from your private health insurance company for these costs. Please call or write us for further information about our charges.



What if I get sick at home?

VA Clinic of Monterey is a clinic/office type operation. Emergency services and hospitalization will be available at the Palo Alto Veterans Affairs Medical Center. Visits to private physicians and costs accrued for transportation and treatment of acute illnesses at other facilities than the VA Clinic of Monterey and Palo Alto Veterans Affairs Medical Center may be your responsibility.

If you become acutely ill, you may call 911 for immediate assistance or our office during normal operating hours for consultation with a physician or nurse. After 5:00 pm on weekdays, and on weekends and holidays, you may call 911 for emergencies or (415) 852-3200 to consult with Palo Alto Veterans Affairs Medical Center staff.

If your illness occurs outside our clinic (home, office, etc.) and immediate transportation, emergency service, or hospitalization are required, this may be at your expense. If you require hospitalization elsewhere, you will be offered transfer, as soon as medically safe, to the Palo Alto Veterans Affairs Medical Center. Patients who are found to be ill at our clinic will have all their immediate care needs provided at VA expense.

We look forward to being your health care provider in Monterey County. We encourage you to call or write with questions, for registration materials or to make an appointment.

APPENDIX H

Health Care Benefits

Hospital and Nursing-Home Care

Eligibility for VA hospital care and nursing-home care is divided into two categories: "mandatory" and "discretionary." VA must provide hospital care and may provide nursing-home care to veterans in the mandatory category. VA may provide hospital and nursing-home care to veterans in the discretionary category if space and resources are available in VA facilities. VA makes an income assessment to determine whether a nonservice-connected veteran is eligible for cost-free VA medical care. These income levels are adjusted on Jan. 1 of each year, based on the percentage of increase provided to VA improved-pension benefits.

The law requires that VA must provide hospital care to veterans in the mandatory category at the nearest VA facility capable of furnishing the care in a timely fashion. If no VA facility is available, care must be furnished in a Defense Department facility or another facility with which VA has a sharing or contractual relationship. If space and resources at VA hospitals and nursing homes are available after caring for service-connected veterans, then VA may furnish care to those in the discretionary category. Veterans in the discretionary category must agree to pay VA for their care.

Veterans who must be provided hospital care and may be provided nursing-home care and who are not subject to an income eligibility assessment are: veterans with service-connected disabilities, veterans who were exposed to herbicides while serving in Vietnam, veterans exposed to ionizing radiation during atmospheric testing or in the occupation of Hiroshima and Nagasaki, veterans for a condition related to service in the Persian Gulf, former prisoners of war, veterans on VA pension, veterans of the Mexican Border period or World War I and veterans eligible for Medicaid. The following income eligibility assessment applies to all other nonservice-connected veterans:

MANDATORY: Veterans must be provided hospital care if the patient is a nonservice-connected veteran with income of $19,912 or less if single with no dependents, or $23,896 or less if married or single with one dependent. The income maximum is raised $1,330 for each additional dependent. Hospital care in VA facilities must be provided to veterans in the mandatory category. Nursing-home care may be provided in VA facilities, if space and resources are available.

DISCRETIONARY: Veterans may be provided hospital care if the patient is a nonservice-connected veteran and income is above $19,912 if single with no dependents, or $23,896 if married or single with one dependent, plus $1,330 for each additional dependent. The patient must agree to pay an amount equal to what would have been paid under Medicare. The Medicare deductible currently is $696 and is adjusted annually. VA may provide hospital, outpatient and nursing-home care in VA facilities to veterans in the discretionary category, if space and resources are available.

If the patient's medical care is considered discretionary, VA holds the patient responsible for the cost of care up to $696 for the first 90 days of care during any 365-day period. For each additional 90 days of hospital care, the patient is charged half the Medicare deductible. For each 90 days of nursing-home care, an amount equal to the Medicare deductible is charged. In addition to these charges, the patient will be charged $10 per day for hospital care and $5 a day for nursing-home care.

How Income Is Assessed

The patient's total income under the eligibility assessment includes Social Security, U.S. Civil Service retirement, U.S. Railroad Retirement, military retirement, unemployment insurance, any other retirement income, total wages from all employers, interest and dividends, workers' compensation, black lung benefits and any other gross income for the calendar year prior to application for care. The income of spouse and dependents as well as the market value of stocks, bonds, notes, individual retirement accounts, bank deposits, savings accounts and cash also are used. Debts are subtracted from the patient's assets to determine net worth. The patient's primary residence and personal property are excluded. The patient must fill out VA Form 10-10f, Financial Worksheet, at the time care is requested. VA has the authority to compare information provided by the veteran with information obtained from the Department of Health and Human Services and the Internal Revenue Service.

Billing Insurance Companies

All veterans applying for medical care at a VA facility will be asked if they have medical insurance. VA is authorized by law to bill insurance companies for the cost of medical care furnished to veterans, including service-connected veterans, for nonservice-connected conditions covered by health insurance policies. A veteran may be covered by such a policy or be covered as an eligible dependent on a spouse's policy. Veterans are not responsible and will not be charged by VA for any charge required by their health-insurance policies. Veterans will not be responsible for uncovered charges from the insurance company, except for copayments required by federal law.

Nursing-Home Care

Benefit

Skilled nursing care and related medical care in VA or private nursing homes is provided for convalescents or persons who are not acutely ill and not in need of hospital care.

Eligibility

Admission or transfer to VA nursing-home care is the same as for hospital care. Veterans who have a service-connected disability are given first priority. Direct admission to private nursing homes at VA expense is limited to: (1) a veteran who requires nursing care for a service-connected disability after medical determination by VA, (2) any person in an Armed Forces hospital who requires a protracted period of nursing care and who will become a veteran upon discharge from the Armed Forces, and (3) a veteran who had been discharged from a VA medical center and is receiving home health services from a VA medical center. VA may transfer veterans who need nursing-home care to private nursing homes at VA expense from VA medical centers, nursing homes or domiciliaries. VA-authorized care normally may not be provided in excess of six months, except for veterans whose need for nursing-home care is for a service-connected disability or for veterans who were hospitalized primarily for treatment of a service-connected disability. Nursing-home care may be authorized for nonservice-connected veterans whose income exceeds the income limit for hospital care if the veteran agrees to pay the applicable copayment.

Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health-maintenance care for veterans who require minimal medical care but who do not need the skilled nursing services provided in nursing homes. VA provides domiciliary care to veterans

whose annual income does not exceed the maximum annual rate of VA pension and to veterans the Secretary of Veterans Affairs determines have no adequate means of support.

Outpatient Medical Treatment

Benefit

Outpatient medical treatment includes medical examinations and related medical services, drugs and medicines, rehabilitation services, and mental health services. As part of outpatient medical treatment, veterans may be eligible for home health services for the treatment of disabilities.

Eligibility

1. VA must furnish outpatient care without limitation to:
   - Veterans for service-connected disabilities.
   - Veterans with a 50 percent or more service-connected disability, for any disability.
   - Veterans who have suffered an injury as a result of VA hospitalization, for that condition only.

2. VA must furnish outpatient care for any condition to prevent the need for hospitalization, to prepare for hospitalization or to complete treatment after hospital care, nursing-home care or domiciliary care to:
   - 30-40 percent service-connected disabled veterans.
   - Veterans whose annual income is not greater than the maximum annual pension rate of a veteran in need of regular aid and attendance.

3. VA may furnish outpatient care without limitation to:
   - Veterans in a VA-approved vocational rehabilitation program.
   - Former prisoners of war.
   - World War I or Mexican Border Period veterans.
   - Veterans who receive increased pension or compensation based on the need for regular aid and attendance of another person, or who are permanently housebound.

4. VA may furnish outpatient care to prevent the need for hospitalization, to prepare for hospitalization, or for a condition for which the veteran was hospitalized to:
   - 0-20 percent service-connected disabled veterans.
   - Veterans exposed to a toxic substance during service in Vietnam; or to ionizing radiation following the detonation of a nuclear device; or to environmental contaminants in the Persian Gulf Theater, for conditions related to such exposures.
   - Mandatory category veterans whose income is more than the pension rate of a veteran in need of regular aid and attendance.
   - Discretionary category veterans, subject to a copayment of $36 per outpatient visit.
   - Allied beneficiaries, beneficiaries of other federal agencies and certain other nonveterans.

5. Counseling for Women Veterans. Counseling is provided to any woman veteran who requires it to overcome psychological trauma resulting from physical assault, battery of a sexual nature or sexual harassment during active duty. The counseling is provided at VA medical centers and Vet Centers.

Outpatient Pharmacy Services

Veterans receiving medication for treatment of service-connected conditions and veterans rated with 50 percent or more service-connected disability are not charged

for pharmacy services. Veterans whose annual income does not exceed the maximum VA pension are not charged. Veterans with a service-connected condition rated less than 50 percent receiving medication on an outpatient basis from VA facilities for the treatment of nonservice-connected disabilities or ailments are charged $2 for each 30-day supply or less.

Outpatient Dental Treatment

Outpatient dental treatment may include examinations and the full spectrum of diagnostic, surgical, restorative and preventive techniques.
(a) Dental conditions or disabilities that are service connected and compensable in degree will be treated.
(b) Service-connected dental conditions or disabilities that are not compensable in degree may receive one-time treatment if the conditions can be shown to have existed at discharge or within 180 days of release from active service. Veterans who served on active duty for 90 days or more during the Persian Gulf War are included in this category. Veterans must apply to VA for care for the service-connected dental condition within 90 days following separation. Veterans will not be considered eligible if their separation document indicates that necessary treatment was completed by military dentists during the 90 days prior to separation.
(c) Service-connected, noncompensable, dental conditions resulting from combat wounds or service injuries, and service-connected, noncompensable, dental conditions of former prisoners of war who were incarcerated less than 90 days may be treated.
(d) Veterans who were prisoners of war for more than 90 days can receive complete dental care.
(e) Veterans can receive complete dental care if they are receiving disability compensation at the 100-percent rate for service-connected conditions or are eligible to receive it by reason of unemployability.
(f) Nonservice-connected dental conditions that are determined by VA to be associated with an aggravated, service-connected medical problem can be treated.
(g) Disabled veterans participating in a vocational rehabilitation program will be treated.
(h) Veterans can be treated for nonservice-connected dental conditions or disabilities when treatment was begun while in a VA medical center, when it is professionally determined to be reasonably necessary to complete such dental treatment on an outpatient basis.
(i) Veterans scheduled for admission to inpatient services or who are receiving medical services can be provided outpatient dental care if the dental condition is professionally determined to be complicating a medical condition currently under treatment by VA.

Nonservice-connected veterans who are authorized outpatient dental care may be billed the applicable copayment if their income exceeds the maximum threshold.

Persian Gulf, Agent Orange and Ionizing Radiation

Registry Examination Programs

Under the auspices of VA's Persian Gulf, Agent Orange and Ionizing Radiation Registries, veterans who served in the Persian Gulf War or who claim exposure to Agent Orange or atomic radiation are provided with free, comprehensive medical examinations, including base-line laboratory tests and other tests determined necessary by an examining physician to determine current health status. Results of the examinations, which include completion of a questionnaire about the veteran's military service and exposure history, are entered into special, computerized programs maintained by VA. These data bases assist VA in analyzing the types of health conditions being reported by veterans. Registry participants are advised of

the results of their examinations by personal consultation. Each registry serves as an outreach mechanism which assists VA in providing participants with significant information of concern to them. Veterans wishing to participate should contact the nearest VA health-care facility to request an examination. Appointments generally can be arranged within two to three weeks.

Agent Orange, Nuclear Radiation and Environmental Contamination Treatment

VA provides priority treatment to any Vietnam-Era veteran who, while serving in Vietnam, may have been exposed to dioxin or to a toxic substance in a herbicide or defoliant used for military purposes. Priority health-care services are available for any veteran exposed to ionizing radiation from the detonation of a nuclear device in connection with nuclear tests or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning Sept. 11, 1945, and ending July 1, 1946. Treatment was authorized through June 30, 1994, for veterans exposed to Agent Orange or nuclear radiation. VA also provides priority treatment to any Persian Gulf veteran who requires treatment for a condition medically determined to be possibly related to service in the Persian Gulf area.

Beneficiary Travel

Payment or reimbursement for travel costs to receive VA medical care, called beneficiary travel payment, may be made to the following:

(a) Veterans whose service-connected disabilities are rated at 30 percent or more.
(b) Veterans who are traveling in connection with treatment of a service-connected condition.
(c) Veterans who are in receipt of VA pension.
(d) Veterans traveling in connection with a compensation and pension examination.
(e) Veterans whose income is less than or equal to the maximum base VA pension rate.
(f) Veterans whose medical condition requires use of a special mode of transportation, if the veteran is unable to defray the costs and travel is pre-authorized — unless the medical condition is a medical emergency.

Travel is subject to a deductible of $3 for each one-way trip — with an $18 per month cap. Two exceptions to this rule are travel for a compensation and pension examination and travel by special modes of transportation.

Counseling for Persian Gulf Veterans

Marital and family counseling is provided to veterans of the Persian Gulf War and their spouses and children. The counseling is provided at VA medical centers and Vet Centers.

Counseling for Sexual Trauma

Counseling may be furnished to a woman veteran to overcome psychological trauma which, in the judgment of a mental health professional employed by VA, resulted from physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while serving on active duty.

Alcohol and Drug Dependence Treatment

Veterans without service-connected disabilities whose incomes exceed the threshold for free medical care may be authorized treatment for alcohol and drug dependence only if the veteran agrees to pay the applicable copayment. After hospitalization for alcohol or drug treatment, veterans may be eligible for outpatient care or may be

authorized to continue treatment or rehabilitation at VA expense in private facilities such as halfway houses.

Prosthetic Services

Veterans may apply for prosthetic services to treat any condition when receiving hospital, domiciliary or nursing-home care in a VA facility. Veterans who meet the basic requirements for outpatient medical treatment may be provided needed prosthetic services:

(1) For a service-connected disability or adjunct condition.
(2) For any medical condition for a veteran with a service-connected disability rated at 50 percent or more or for a veteran receiving compensation as a result of treatment in a VA facility.
(3) For a disability for which a veteran was discharged or released from active service.
(4) For a veteran participating in a rehabilitation program under 38 USC Chapter 31.
(5) As part of outpatient care to complete treatment of a disability for which hospital, nursing home or domiciliary care was provided.
(6) For a veteran in receipt of increased pension or allowance based on needing aid and attendance or being permanently housebound.
(7) For a veteran of World War I or the Mexican Border period.
(8) For a former prisoner of war.

Blind Aids and Services

Veterans are eligible to receive VA aids for the blind if their blindness is a service-connected disability, if they are entitled to compensation from VA for any service-connected disability or if they are eligible for VA medical services. Veterans with corrected vision of 20/200 or less in the better eye or field defect of 20 degrees or less are considered to be blind. Blind veterans need not be receiving compensation or pension to be eligible for admission to a VA blind rehabilitation center or clinic, or to receive services at a VA medical center. Benefits include:

(a) A total health and benefits review by a VA Visual Impairment Services Team (VIST)
(b) Adjustment to blindness training.
(c) Home improvements and structural alterations to homes (HISA Program).
(d) Specially adapted housing and adaptations.
(e) Low-vision aids and training in their use.
(f) Approved electronic and mechanical aids for the blind, and their necessary repair and replacement.
(g) Guide dogs, including the expense of training the veteran to use the dog and the cost of the dog's medical care.
(h) Talking books, tapes and Braille literature, provided from the Library of Congress.

Readjustment Counseling

Veterans who served on active duty during the Vietnam Era or served in the war or conflict zones of Lebanon, Grenada, Panama or the Persian Gulf theaters during periods of hostilities or war are entitled to counseling to assist in readjusting to civilian life.

Counseling is provided at Vet Centers of the VA's Readjustment Counseling Service to help veterans resolve war-related psychological difficulties and to help them achieve a successful post-war readjustment to civilian life. Assistance includes group, individual and family counseling, community outreach and education. Vet Center staff help veterans find services from VA and non-VA sources if needed. One common readjustment problem is post-traumatic stress disorder, or PTSD.

This refers to such symptoms as nightmares, intrusive recollections or memories, flashbacks, anxiety or sudden reactions after exposure to traumatic conditions. Readjustment difficulties may affect functioning in school, family or work. Counseling also is provided veterans for difficulties due to sexual assault or harassment while on active duty.

The location of the nearest Vet Center usually can be found in the U.S. Government section of the phone book under Department of Veterans Affairs. All Vet Centers are listed in the back of this booklet. In areas which are distant from Vet Centers or VA medical facilities, veterans may obtain readjustment counseling from private sector counselors, psychologists, social workers or other professionals who are on contract with VA. To locate a contract provider, contact the nearest Vet Center.

Income Verification Matching

Income of veterans receiving VA medical care based on income is verified with records maintained by the Internal Revenue Service and the Social Security Administration. Service-connected veterans are not subject to the verification even when evaluated or treated for a nonservice-connected condition. The purpose of the verification is to ensure proper VA medical care is administered to eligible veterans.

Home Improvements and Structural Alterations

The Home Improvements and Structural Alterations (HISA) program helps pay for home improvements necessary to assume continuation of treatment or provide access to the home and essential lavatory and sanitary facilities. For alterations, VA will pay up to $4,100 for veterans being treated for a service-connected disability, and up to $1,200 for the nonservice-connected disability of a veteran receiving post-hospital care or a veteran rated 50 percent or more disabled.

Medical Care for Merchant Seamen

Those Merchant Marine seamen whose World War II service qualifies them for veterans' benefits must present their DD-214 discharge certificate when applying for medical care benefits at VA medical centers. VA regional offices can provide information on obtaining a certificate.

Medical Care for Allied Veterans

VA is authorized to provide reciprocal medical care to veterans of nations allied or associated with the United States during World War I or World War II. Such treatment is available at any VA medical facility but must be authorized and reimbursed by the foreign government. VA also is authorized to provide hospitalization, outpatient and domiciliary care to former members of the armed forces of the governments of Czechoslovakia or Poland who participated during World Wars I and II in armed conflict against an enemy of the United States, if they have been citizens of the United States for at least 10 years. Benefits are the same as those provided to U.S. veterans.

Medical Care for Dependents and Survivors (CHAMPVA)

The VA Civilian Health and Medical Program, known as CHAMPVA, shares the cost of medical services and supplies obtained by eligible dependents and survivors of certain veterans. The following are eligible for CHAMPVA benefits, provided they are not eligible for medical care under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) or Medicare, Part A, as a result of reaching age 65:

(a) The spouse or child of a veteran who has a permanent and total service-connected disability.
(b) The surviving spouse or child of a veteran who died as a result of a service-connected condition; or who at the time of death was permanently and totally disabled from a service-connected condition.
(c) The surviving spouse or child of a person who died while on active military service in the line of duty.

Beneficiaries age 65 or older who lose eligibility for CHAMPVA by becoming potentially eligible for Medicare, Part A, or who qualify for Medicare, Part A, benefits on the basis of a disability may re-establish CHAMPVA eligibility by submitting documentation from the Social Security Administration certifying their nonentitlement to or exhaustion of Medicare, Part A, benefits. Persons under age 65 who are enrolled in both Medicare Parts A and B may become eligible for CHAMPVA as a secondary payer to Medicare. Apply to the CHAMPVA Center, 4500 Cherry Creek Drive South, Denver, CO 80222, or call 1-800-733-8387.

Homeless Veterans

A number of VA benefits assist eligible homeless veterans, including disability compensation, pension, education and burial benefits. Homeless veterans also are provided special assistance through many program initiatives.

VA also continues to expand its health and rehabilitation programs for homeless veterans. Homeless Chronically Mentally Ill Veterans programs at 50 sites provide comprehensive medical, psychological and rehabilitation treatment programs through case management and community-based residential care. Domiciliary Care for Homeless Veterans programs at 31 sites provide active residential rehabilitation services. VA has a growing number of Compensated Work Therapy/Therapeutic Residence group homes; special day-time, drop-in centers; and Comprehensive Homeless Centers.

VA has joined with the Department of Housing and Urban Development, the Social Security Administration, veterans service organizations, and community nonprofit homeless service providers in special partnerships that help VA provide comprehensive care for homeless veterans. For information, contact the nearest VA regional office or medical center.

APPENDIX I

Memorandum of Understanding (MOU)
between FORA and MoReHEALTH

MEMORANDUM OF UNDERSTANDING

This is to affirm that, whereas the Fort Ord Reuse Authority has been authorized responsibility for "acquiring and disposing of existing real property and facilities within the territory of Fort Ord; to plan, finance and construct new public capital facilities within that territory, and to levy assessments, reassessments, special taxes, or development fees and to issue bonds to finance projects in accordance with specified state statutes"; and whereas Monterey Regional Health Development Group (MoReHEALTH) has been created to "focus on coordinated community health strategies that identify and implement initiatives to address health and health care needs emerging from the closure of Fort Ord; bring a regional perspective to the area's healthcare resources; bring a strong voice of advocacy for addressing the health of under-served and unserved individuals in the region; and act as a major proponent for health promotion and education of the region's population; this memorandum of understanding between FORA and MoReHEALTH will authorize MoReHEALTH to prequalify proposals planning the development and implementation of a continuing care retirement community (CCRC) on properties at Fort Ord. All organizations interested in these developments must submit their proposals and business plans initially through MoReHEALTH, which will review, rank order and present recommendations to FORA. Additionally, MoReHEALTH will serve as advisor to FORA for the development and operation of any CCRC program at Fort Ord.

Jack D. Barlich
Chair, Fort Ord Reuse Authority

Nov. 10, 1994
Date

William H. Gourley, MG, USA (Ret.)
Chair, Monterey Regional Health Development Group

21 NOV 94
Date

APPENDIX J

Healthcare Forum *Healthier Communities* Conference
scheduled for April 22-25, 1995

Introducing "Optimizing Health of a Defined Population" Learning Lab

1995 HEALTHIER COMMUNITIES SUMMIT

BUILDING SYSTEMS FOR SUSTAINABLE HEALTH

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APPENDIX J

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Learning Objectives

- Develop your integrated health system into a complete continuum of care for a diverse population, emphasizing prevention and wellness.
- Explore strategies to engender community-wide collaboration to improve health status through improvements to social, cultural, economic and environmental factors.
- Understand how healthcare leaders can support and sustain natural healing systems in communities.
- Strengthen shared vision and reduce boundaries by furthering your understanding of public opinion and consumers' roles.
- Learn to create a web of inter-relationships that sustain development, through use of advanced communication and information technologies.
- Build key leadership competencies and values needed for 21st-century leaders.
- Explore best practices and successful models from throughout the world.

The Environment Is New, Changing, Evolving—at an unprecedented pace. How can you ensure that what's redesigned today is built to last?

The healthcare systems that survive, even thrive, into the next decade will be those that align today's activities—from redesign to restructuring to building new relationships—with future development. Systems that balance near-term success with long-term survival and sustainability.

Mark April 22-25 on your calendar and prepare your leadership team for one of the most powerful learning experiences ever: The 1995 Healthier Communities Summit in San Diego, California.

The Summit Guides You Through the Current Confusion. Builds the capacity of your team, your organization and your community to reinvent the future of healthcare. A future grounded in sustainable systems to *create* health and healing.

Here you'll explore business strategies that align today with tomorrow—both in creating healthier communities and balancing the budget. Over three days that combine focused exploration and idea-sharing with networking and enjoyment of springtime San Diego, you and your team will meet with delegates from around the globe. You'll share successes, identify pitfalls and discover the rewards of improving health status and quality of life.

This World-Class Gathering of Leaders—

both the pioneers in the healthier communities movement and the newly initiated— is a vibrant and inspirational community of learners. Don't miss the opportunity to network with your peers, expand your thinking and explore workable models for creating sustainable improvements to community health status and quality of life. And use this opportunity to introduce influential board members, community leaders and colleagues to the compelling logic of creating healthier communities.

An Unparalleled Learning Experience,

this is the most hands-on Summit yet. Giving you the guidelines, models and how-to's of working with all sectors of your community to create fundamental, sustainable change. Offering six inspirational Community Forums that anchor the Summit experience, and more than 30 provocative Educational Forums.

Plus, an Innovation and Technology Center that inspires new thinking and offers new solutions...peer consulting sessions with leading Summit faculty...the new interactive Healthier Communities Fair featuring poster displays and presentations...the day-long option of Saturday Learning Intensives...introductions to the newest class of Healthier Communities Fellows...and showcasing the Healthier Communities Award winners. Continuing education credit for physicians, nurses and healthcare executives is available (see page 25).

Bring your ideas. Your questions. Your community leadership team. Together we'll recreate healthcare—to last.

Who Will Attend?

Leaders like you who are playing a pivotal role in transforming healthcare. A gathering of innovators and change-agents who are working across disciplines, sectors and traditional boundaries to promote positive health status and quality of life. Teams may be comprised of:

Trustees, Community, Civic and Public Health Leaders • Healthcare industry CEOs, COOs, CFOs, Vice Presidents and Senior Executives • Physician Leaders and Medical Group Administrators • Insurers; HMO, PPO and Managed Care Executives • Policymakers and Opinion Leaders • Educators, Students and Media

SUMMIT AT A GLANCE

Join healthcare's community of leaders in exploring new models, new incentives and new outcomes for sustaining health. Every member of your team benefits from the experience.

SATURDAY, APRIL 22

7 am - 5 pm
Summit Registration Open

8 am - 9 am
Intensives Continental Breakfast

9 am - 4pm
Learning Intensives

- All You Need for a New Universe Is a New Mind
- Physician-Hospital Organizations: A Practical Model
- Self-Organizing Systems: An Exploration of Organization
- Creating Healthier Communities: Theory and Practice
- Raising the Intelligence of Your Organization
- Using Information Technology to Launch the Next Phase of the Healthier Communities Transformation
- Into the Breach: Building Hospital-Physician Collaboration in Risk-Sharing
- Working in the Future
- Optimizing Health of a Defined Population
- Base Closure: From Community Crisis to Healthy Community, Learnings from Fort Ord
- Mastering the Transition to Capitation
- Developing Collaborative Leadership for Healthcare Systems

Corporate Associate: APM

12 - 1:30 pm
Lunch for Intensives participants

SUNDAY, APRIL 23

7 am - 7 pm
Summit Registration Open

10:30 am - 11:15 am
Peer Consultation Discussions

11:30 am - 1:30 pm
Opening Community Forum Brunch—
"Organizing in a Self-Organizing World"
MARGARET WHEATLEY, EDD

2 pm - 3:30 pm
Educational Forums

- The Partnership Approach for Improving Community Health Status
- Population Health in the 21st Century
- 21st Century Home/Self Care
- The Future of the Canadian Healthcare System
- Organizational Characteristics of Successful Integrated Health Systems
- Building Integrated Healthcare Delivery Systems
- Rising from the Ashes: The Health Policy Framework fo Achieving Healthier Communities

3:45 pm - 5 pm
Community Forum—
"Entrepreneurial Leadership"
GIFFORD PINCHOT

5 pm - 7 pm
Innovation & Technology Center
Architectural Design & Planning Exhibit
Opening Gala

7:15 pm - 7:45 pm
Peer Consultation Discussions

We reserve the right to alter programs and speakers based on prevailing circumstances.

STANLEY PAPPELBAUM, MD, is co-founder and managing partner of Professional Health Consulting Group, Del Mar, CA. Pappelbaum's group is a national company of physician executives who are devoted to analyzing and managing change for complex healthcare clients. He specializes in hospital-based cancer center development, hospital medical staff mergers and physician/hospital integrated systems—both community and academic.

8. Working in the Future

What will your workforce of tomorrow look like? How will you change your organization to accommodate new work styles? How can you create a work culture that ensures high performance? Reconciling the needs of the organization and the needs of employees is a complex arena for healthcare leaders. Explore the new requirements and demands of the future workplace to produce higher-value services in a rapidly changing environment. This session will offer new insight into our future workforce, explore strategies to maximize talent and outline actions to ensure successful workplace-workforce partnerships.

DEBORAH PROCTOR is the director of western region, Work Transformation Services at Hay Group, Inc., Walnut Creek, CA. She specializes in the redesign of jobs and work process in hospitals and healthcare systems. Proctor has helped organizations implement patient-focused care, create more effective work cultures that reinforce quality initiatives, design new management systems and develop innovative performance-enhancing reward and recognition programs.

KATHERINE VESTAL, PHD, is national director, US Healthcare Consulting, Hay Group, Inc., Dallas, TX. Vestal's area of expertise is managing the complexities to support continuous quality improvement in patient care and business operations, to improve quality of work life for employees and to reduce costs of providing services. She also assists clients in developing innovative approaches to restructuring the workplace that will positively distinguish the organization in a competitive environment.

9. Optimizing Health for a Defined Population

How do we go about improving healthcare for a given population? In a multimedia learning environment, we'll focus on the role of clinical policymaking and its effect on communities' health status. Through computer simulation, we'll enter a "virtual population," learn about its underlying health status and explore the interdependent system that improves or worsens it. We'll have the opportunity to make policy decisions, and see the effect of those decisions on the community's health. This session offers a clinical perspective, continuing from the work begun in the "Mastering the Transition to Capitation Learning Lab" created by The Healthcare Forum in 1994.

STEVE DEMELLO is the director of health care practice for High Performance Systems, Inc., Oakland, CA. He is responsible for supporting the firm's national base of healthcare consulting clients and users of ithink® and STELLA II® software products. He has substantial experience in systems thinking, corporate planning and marketing for regional health systems, strategic planning and program development and hospital operations.

10. Base Closure: From Community Crisis to Healthy Community, Learnings from Fort Ord

The Monterey, California area recently was faced with a crisis: Its 440-bed Army hospital was scheduled for termination, as part of the largest military base closure in 15 years. What could and should be done? Members of the community met to focus on health and quality of life issues for the remaining military and civilian population. They organized, researched and worked to solve the problems resulting from the closures. Their efforts netted them the designation of "National Model for Future Base Closures" by Secretary of Defense William Perry. Learn from the success of Fort Ord, and be better prepared for a base closure or other catastrophic event in your area.

Frederick Pang is Assistant Secretary of Defense for Force Management, Washington, DC. He acts on all matters pertaining to military and civilian manpower and personnel in the Department of Defense. He has Defense-wide policy responsibility for the recruitment, training, career development, compensation, retention, equal opportunity and quality of life of Defense personnel.

William Gourley is a retired major general of the US Army, now residing in Monterey, CA. After 35 years of active military service, he founded and now chairs the Monterey Regional Health Development Group, Inc., a nonprofit organization continuing the planning efforts to improve healthcare status in the Monterey County area.

David Sevier, Commander, US Navy, is the executive director of the Defense Health Resources Study Center at the Naval Postgraduate School, Monterey, CA. He established the Study Center in 1991 after serving on the staff of the Assistant Secretary of Defense for Health Affairs. He is Executive Secretary of the Monterey Regional Health Development Group, Inc. and is an inaugural board member. Sevier co-authored the Monterey Regional Health Strategy.

Barbara Shipnuck is Chair of the Monterey County Board of Supervisors, Monterey, CA. She is also vice-chair of the Fort Ord Reuse Authority (FORA). Shipnuck was named "County Leader of the Year" in 1993 by *American City and County* magazine for her work on health system reform. She serves on the Monterey Regional Health Development Group, Inc. Board of Directors.

11. Mastering the Transition to Capitation

If your organization is, or soon will be, struggling with the new demands of managed care and capitation, the 1995 Healthier Communities Summit is an excellent place to explore and test new strategies before you implement them. The Mastering the Transition to Capitation Learning Lab enables healthcare leaders to experiment with ways to make the transition from a fee-for-service or fee-per-case payment system to a managed, capitated environment. Through the Learning Lab, you can begin to understand core systems dynamics of healthcare organizations, and test ideas for improving business performance. Developed by The Healthcare Forum, the Learning Lab provides a rare opportunity to see, in a matter of hours, the ways your thinking might play out over the long term.

Bette Gardner is president of Breakthrough Learning Inc., Morgan Hill, CA. She is a management consultant using systems thinking and related disciplines in her work with client organizations. Gardner designs and conducts seminars on integrating the disciplines of systems thinking into daily practice and assists clients in managing strategic and operational problems. Her outreach is broad, with 20 years' experience in healthcare organization management. She is involved in her local community, where she serves on several healthcare organization boards and teaches at local universities.

12. Developing Collaborative Leadership for Healthcare Systems

Is leadership something we're born with? Perhaps, but in this session, you will also come to understand leadership as a set of skills that can be acquired. Begin to experience the contribution of systems thinking, mental models and dialogue to building collaborative relationships over time. Investigate the link between personal skill enhancement and team development.

Alain Gauthier is executive director of Core Leadership Development, Oakland, CA. He is also a visiting professor at the Lyons (France) Graduate School of Business. Gauthier offers 30 years of experience in strategic management and organizational redesign. He has served a large variety of client organizations in Europe and North America, first as an associate of McKinsey & Company, then as an independent consultant. He facilitates retreats with senior leadership groups, including physician leaders, executives and trustees, for a number of healthcare systems.